

## DOCTOR OF PHILOSOPHY

### A phenomenological study exploring ED nurses' experiences of older people's dignity

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# **A Phenomenological Study Exploring ED Nurses' Experiences of Older People's Dignity**

**By**

**Bhupinder Kaur Pawar**

**September 2016**



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***A thesis submitted in partial fulfilment of the University's requirements for the  
Professional Doctorate Degree in Health and Social Care***

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## **Abstract**

**Introduction:** Following a number of high profile reports into health care delivery in the NHS, such as the Mid Staffordshire NHS Trust inquiry (Francis 2013), emphasis on maintaining older people's dignity in health care is of paramount importance. Demographic shifts and an increase in the proportion of older people in the general population mean that the emergency department (ED) is, and will be, the entry portal to acute health care services for many older people. In line with all care settings, nurses are, and will continue to be, the main providers of care in ED. Dignified care of older people should start at the 'portal' entry through which older people start their health care journey. There is lack of evidence investigating the experiences of ED nurses in relation to older people's dignity in the emergency department. The aim of this study was to explore ED nurses' experiences of caring for older people in one ED, to describe their perceptions of dignity and factors that can facilitate or hinder dignified care.

**Study Design:** This was an exploratory qualitative study, guided by a descriptive phenomenology methodology. Ten experienced emergency care nurses were recruited in one emergency department using purposive sampling. Data were collected through semi-structured interviews, which were audio recorded and transcribed verbatim. Data were analysed using Colaizzi's (1978) data analysis approach.

**Findings:** The findings indicated that nurses perceived older patients' dignity in the ED as actions inherent to autonomy. Dignity was conceptualised as seeing and treating the older person as an individual human being. Participants described respecting the older person, maintaining privacy and giving information and choice as attributes of older person's dignity. The ED was described as a complex care environment that included a number of factors that hindered nurses from providing dignified care. Lack of privacy was one of the

main factors that compromised patient dignity in ED. Other factors identified as hindering delivery of dignified care related to poor staffing levels, and pressures of meeting specific government targets imposed on the emergency care service provision. Nursing patients in corridors was described as the worst area for maintaining older people's dignity.

**Conclusion:** The research revealed that nurses understood what constituted dignified care and were capable of delivering this care. However, the complex ED environment prevented them from delivering this care.

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## Dedication

*I dedicate this thesis and my nursing career to my late mother, Kulwarn Kaur, who was instrumental in my chosen career, my academic and professional achievements. Despite being illiterate herself, she understood the value of education and encouraged and supported me to achieve my professional and academic goals. I will never forget the pride and joy on her face when I first qualified as a nurse and later completed my master's degree. Her pride and delight when I commenced on my professional doctorate journey back in 2009 was phenomenal. Sadly, she is not here to see me come to the end of this long journey, but I know she would be proud. Thank you Mattaji, for being a wonderful mum, and for instilling me with the seeds of education.*

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## **Chapter 1: Introduction**

There is very little research investigating the experiences of emergency care nurses in relation to older people's dignity in the emergency department (ED). Older people make up the largest single group of people accessing the National Health Service (NHS) and as a group they consume over 40 per cent of healthcare resources (Help the Aged 2002). Patients over the age of 65 account for 18 per cent of all emergency attendances (Downing & Wilson 2005). Many older people are admitted to hospital through the ED, have a longer length of stay, and occupy more bed days in acute hospitals compared to other patient groups (British Geriatric Society 2012).

In the United Kingdom (UK) the ED provides preliminary care and treatment to a diversity of people, including older patients who present with a wide range of conditions. Emergency departments are often described as the 'front doors' through which many patients start their health care journeys (Ford et al 2008). The majority of ill patients attending ED require immediate care and nurses' attention is frequently focused on providing life-saving or urgent physical interventions (Ford et al 2008), rather than individualised care. The ED setting is characterised as a fast-paced, technologically-focused and highly specialised environment for individuals with life-threatening illness (Nolan 2009). Evidence suggests that ED nurses view their role as being predominantly concerned with providing urgent physical care (Byrne & Heyman 1997) and are not attuned to the needs of older people. Kihlgren et al (2004) reported that ED nurses find the demands of prioritising medical procedures and urgent care tasks threaten the standards of nursing care provided to older patients. They further suggested that nurses considered the level of care provided in ED is inappropriate for the needs of older patients. Other studies (Robinson and Mercer 2007; Kilcoyne and Dowling 2007) indicate that most EDs are not adjusted to providing care to older people. Nurses in ED are challenged to maintain the standard of practice that combines their knowledge and skills in dealing with emergency situations

with the basic care that promotes older patients' dignity (Robinson and Mercer 2007).

The notion of human dignity in relation to care of older people has become a significant issue in United Kingdom health policy. The concept of human dignity is neither new nor only relevant to the UK, but is relevant to all human beings: there seems to be a global consensus that dignity is an important concept to every individual in every society (Matiti 2011: 3). Human dignity is further embedded and expressed in a number of declarations of human rights, including the United Nations Universal Declaration of Human Rights (UNUDHR 1948) and the UK's Human Rights Act (1998). In UK health policy, there has been a great deal of rhetoric about the dignity of older people (Gallagher et al 2008). The last two decades have seen the publication of a number of government health care policies, guidelines and campaigns focusing on the dignified care of older people. The emphasis placed on dignity means that it cannot be ignored as an issue for health care professionals (Gallagher et al 2008), especially nurses in any care setting, including ED.

Professional bodies, such as the Nursing and Midwifery Council, and government policies and guidelines emphasise the importance of respect for human dignity. Whilst the dignity of older people has become an essential focus politically and in the NHS, respect for a person's dignity is also an essential value of nursing care and relevant to all human beings. As Coventry (2006) notes:

*'Throughout the nursing and health care field, from ante-natal nursing through acute and chronic illness to aging and terminal care, references to care with dignity and the right to dignity and respect can be found' (p46).*

However, a number of high profile reports have highlighted that dignity is still denied to many older people in health care settings (Levenson 2007). The Mid

Staffordshire Trust Inquiry chaired by Sir Robert Francis, Q.C. raised many issues about the extent of poor and undignified care of older people (Francis 2013). The Parliamentary and Health Service Ombudsman (PHSO) report, *Care and Compassion?* told the stories of ten older people whose poor care led to distress and loss of dignity. This report highlighted a system-wide failure of NHS Trusts across England to meet the most basic standards of care needs of older patients and makes very uncomfortable reading. It found that older people were left in soiled or dirty clothes and were not washed or bathed. Many were left in pain and even basic care such as adequate food and drink was denied to them and call bells were placed out of reach. The themes of poor communication, dismissive response to pain management, dismissive attitudes of staff, and poor standards of basic care were identified. The nature of the failings highlighted in the report contributed to the ten patients' deteriorating health, during which they were transformed from alert and able individuals to people who were dehydrated, malnourished or unable to communicate. Nine of the ten people featured in this report died due to the poor care they received (PHSO 2011).

The inspiration to investigate older people's dignity from the ED perspective was stimulated by reading and reviewing the reports already discussed and personal experiences of being a daughter of an elderly parent and an ED nurse. As a nurse, I work in a busy ED and I have experienced first-hand the impact that working in an unpredictable environment of chaos and high acuity can have on patient care. Emergency nurses provide care to every person who attends ED, even when the acuity and volume of patients is beyond the service capacity of any given ED (Wolf et al 2016).

Demographic shifts and an increase in the proportion of older people in the general population mean that for many older people ED is, and will be, the entry portal to acute health care services (Considine et al 2010). As in all health care settings, nurses are, and will continue to be, the main providers of ED care. Respecting older people's dignity should be a nursing care priority in the ED.

Dignified care should start at the 'portal' entry or the 'front door' through which older people start their health care journey. The present focus of nursing care in ED is associated with biomedical science, where competency in technical skills such as inserting intravenous lines and invasive monitoring is dominant (Edwards & Griffiths 2011: 1; Marchuk 2014). A study exploring ED nurses' views and perceptions of older people's dignity is certainly warranted.

Holloway and Wheeler (2010: 32) opine that a research area or topic should be of importance to patients, health professionals and society in general. In current health care delivery, the emphasis on older people's dignity is of paramount importance. Although a number of studies have focused on older people and health care professionals' views and experiences of dignity in settings such as nursing homes, medical and surgical wards, to the best of my knowledge, no study has yet explored the notion of human dignity from either the older patients' or the nurses' perspective in the ED. This study attempts to fill the gap by exploring the notion of dignity from the perspective of the ED nurses, who are the key care providers.

### **The Concept of Dignity and Nursing**

The term dignity is often used in relation to care delivery (Webster and Bryan 2010) and it is regarded, as one of the most important principles of nursing philosophy (Wainwright & Gallagher 2008). The concept of dignity is widely embedded within statutory Nursing Codes of Conduct worldwide. In the United Kingdom, the Nursing and Midwifery Council (NMC), the regulator of nursing and midwifery takes a similar position. The core function of the NMC is to establish professional standards of practice, behaviour and education for nursing and midwifery and to ensure those standards are maintained, thereby safeguarding the health and well-being of the public (NMC 2015). While dignity appears to be a duty and a right in all the professional nursing standards and codes internationally, it is also a human rights framework (Gallagher 2004).

In most healthcare settings, national and local policies are in place to support the need to provide dignity in care for older people (Cairns et al 2013). Recent evidence further suggests that older people and their relatives also understand the significance of dignified care (Cairns et al 2013). The NMC's recently revised code places public expectations at the heart of nursing and midwifery practice by providing a set of standards that reflect changes in contemporary professional nursing and midwifery practice, as well as wider expectations of health and social care. Its focus is to drive improvement in the quality and safety of care provided by nurses and midwives (NMC 2015). All registered nurses have a commitment to uphold these standards, which are also fundamental to being part of the profession.

Nursing care are actions directed towards helping, supporting, or enabling individuals with evident or anticipated needs to restore or improve a human condition or life way (Leininger 1988). The value of caring is essential to nursing and critical to nursing services, regardless of the clinical environment (Tuck et al 1998). According to Watson (1985), caring is an intersubjective process that requires sharing one's personal, spiritual, moral, and social self (Watson 1985: 31). More significantly, caring calls for a moral commitment towards protecting human dignity and preserving humanity (Watson 1985: 31). The responsibility for care twenty-four hours a day positions nurses as the professional discipline having the greatest contact with patients (Tuck et al 1998).

Dignity, while much referred to in professional standards and policy documents, is a contested concept, used in many different contexts and is not a new idea (Baillie & Gallagher 2011; Gallagher et al 2008). Human dignity is not a concept exclusive to health care: it is an important consideration in theology, government, business, law, education, design, and practically any profession that involves the interactions of individuals (Coventry 2006). Philosophically, the origins of dignity can be traced as far back as the writings of Aristotle (Gallagher et al 2008). Dignity for Aristotle was a quality, a superiority or moral integrity of



the person, an excellence that contributes to human flourishing or happiness and in which a person can err in terms of excess or deficiency (Gallagher et al 2008). Jacobson (2007) notes that there are two distinct types of dignity: 'human dignity' owned by every human being 'simply by virtue of being human and 'social dignity', which is bestowed or earned. Indeed it is human dignity that is considered to be more relevant to healthcare, especially in relation to older people (Matiti & Trorey 2008). More recently, Nordenfelt (2003, 2004), described four types of human dignity:

*The dignity of Menschenwürde:* Menschenwürde is a German term that refers to the dignity we all have as humans, or are assumed to have, simply because we are humans. This entails that we all have same human rights concept of dignity. In particular, an elderly person has the same basic human rights as the young person (Nordenfelt 2003).

*Dignity as merit:* A person has rights to dignity due to holding a specific position in society. For example, a queen, king or a doctor which is recognised by others (Nordenfelt 2003).

*The dignity of moral status:* This type of dignity emphasises the importance of moral autonomy or integrity and is related to self-respect (Tadd et al 2010). A person who can live according to his or her own moral principles will experience a sense of dignity (Tadd et al 2010). For example, Nelson Mandela, Gandhi, and Aung San Suu Kyi are said to have moral status through their moral principles. Someone who behaves in a cowardly or cruel way may not only lose their self-respect but may also lose the respect of others (Nordenfelt 2003; Tadd et al 2010).

*Dignity of Identity:* This type of dignity is related to self-respect, and reflects an individual's identity as a person. It can be violated by physical interference as

well as by emotional or psychological insults such as humiliation (Tadd et al 2010).

Gallagher et al (2012) stipulates that dignity of identity is nursing practice and refers to one's identity as a person and is related to self-respect. They further elaborate that this kind of dignity can be taken away from people when, for example, they are humiliated, insulted or, treated as objects by others, especially health care professionals. Illness, disability and old age can also rob individuals of their dignity of identity. Frailty, disability and illness, for example, are often irreversible conditions of advancing age and as such severely alter the identity of the elderly (Tadd et al 2012).

Dignity is rooted in nurses' professional standards and all nurses, guided by the code of professional standards, are, and should be familiar with the term dignity and what it means in the context of delivering quality care. The protection of human dignity is central to nurses' work and is demonstrated by the enactment of respect, compassion and sensitivity (Price 2009) in delivery of patient care. There is consensus in the nursing literature that the maintenance of patient dignity is a core element of nursing care that is highly valued by patients (Walsh and Kowanko 2002), their families and carers. Dignified care exists when patients are treated as individuals and where attention is focused on the whole person and not simply on their condition or physical needs (Potter 2009). According to the Royal College of Nursing (RCN): *"When dignity is absent from care, people feel devalued, lacking control and comfort. They may lack confidence, be unable to make decisions for themselves, and feel humiliated, embarrassed and ashamed"* (RCN 2008).

Despite dignity being an important concept within nursing and more widely within health care, there is no standard working definition of dignity (Elaswarapu 2007). While dignity may be difficult to define, it is clear that people know when they have not been treated with dignity and respect (Levenson 2007: SCIE

2006). Several papers have explored nurses' and health care workers' experiences of care practices that promote older people's dignity in various health care settings. Even though there is consensus within literature that health care worker, especially nurses, do recognise and understand the importance of providing dignified care and know what constitutes dignified care; reports still propose that the care provided is suboptimal and do not promote older people's dignity (Levenson 2007).

In care situations dignity is maintained and enhanced through the behaviour of the caregiver (Jacobson 2007), usually a **nurse**. The concepts within the NMC Code of Professional Standards, nursing literature and several government policies provide a set of values with which all professional nurses are familiar. Dignity in relation to care of older people is considered in terms of individualised care, respect, privacy, choice, communication, and appropriate forms of address. However, these have been explored and defined from the perspectives of older people in general, older patients, and health care professionals from care settings such as nursing homes, medical and surgical wards. The concept of dignity has not been researched from the perspective of emergency care nurses in an environment where nursing care is considered to be 'technically orientated'. The researcher as an emergency care nurse identified that in-depth understanding of ED nurses' experiences of caring for older people is essential to discover their perceptions of dignity and the factors that can impact on providing dignified care in the ED.

The mission statement of the American National Institute of Nursing Research (NINR 2015), identify nursing research as: "*Research that promote and improve the health of individuals, families, communities and populations*". Inevitably, nursing research develops knowledge to build the scientific foundations of clinical practice (Parahoo 2014: 13; NINR 2015). Nurses have a crucial part to play in generating a body of knowledge to inform their own practice and improve patient care. Being a nurse and a professional doctorate student, the researcher

is combining a practice and a research focus with the potential to create new and unique knowledge for her colleagues and for the ED in which the study is located (Parahoo 2014: 13; Taylor & Hicks 2009: 51).

### **The Thesis Structure**

This thesis consists of a brief introduction and four other chapters. Chapter two reviews selected literature relating to the dignity of older people. In this chapter literature relating to older people and health care professionals' views and perceptions of dignity are explored and discussed. Chapter three presents the research methodology and procedures selected to achieve the aim of this study. In this chapter the rationale for choosing a qualitative methodology and justification for choosing descriptive phenomenology as the framework for guiding the study are discussed. Chapter four portrays the findings and discussion of this study. Finally, Chapter five brings this thesis to a conclusion with implications to practice.

## **Chapter Two: Literature Review**

### **Introduction**

The principal aim of this chapter is to critically review current research literature related to older people and healthcare professionals' experiences and perceptions of dignity to provide a theoretical background for the present study. The secondary aim was to demonstrate the gap in knowledge and the contribution this study will make to the existing knowledge (Holloway & Wheeler 2010: 36) and understanding of dignity. Finally, the views and perception of dignity and the factors influencing dignified care identified within the literature review will be used to contextualise the findings of the study reported in this thesis.

### **The Place of Literature Review in Qualitative Research**

There is substantial debate about the role of in-depth literature review in qualitative research (Holloway and Wheeler 2010: 37). Some authors argue that in qualitative research, especially in phenomenological studies, conducting an extensive literature review may affect how the researchers collect and analyse data and influence the preconceptions they develop about the phenomenon being studied (Todres & Holloway 2010: 182; Streubert & Carpenter 2011: 25). In contrast, others suggest conducting a preliminary literature review contributes to an understanding of what is already known about the subject, identifies gaps in knowledge and describes how the proposed study may contribute to existing knowledge (Polit & Beck 2014: 54; Holloway & Wheeler 2010: 36). The researcher concluded that a literature review was essential to identify a gap in knowledge which this study intended to address and for justification of the research methodology as component of the ethical approval procedure. In addition, critical review and appraisal of the literature was also a requisite for a previously assessed module assignment submitted as part of this taught modular professional doctorate degree programme.

## Methods

A systematic online search for literature was conducted largely focusing on four electronic databases (CINAHL, MEDLINE, AMED & Cochrane) using the following defined key words: older people, older patients, dignity, nursing, hospital, emergency care, accident and emergency, experience and acute care. In order not to miss any pertinent studies relating to dignity of older people, help from subject librarians was also enlisted to ensure key words, inclusion and exclusion criteria and procedures for searching for evidence was appropriate.

With the demographic changes of increasing numbers of older people in several western countries, the concept of dignity is not unique to the UK. As a result, literature from Europe, Australia and the United States of America (USA) was also sought and included in the review. It was decided to limit to studies published after the year 2000 because lack of respect for dignity became a major concern at the beginning of 2000. Table 2.1 provides the inclusion and exclusion criteria established by the author to identify the articles obtained.

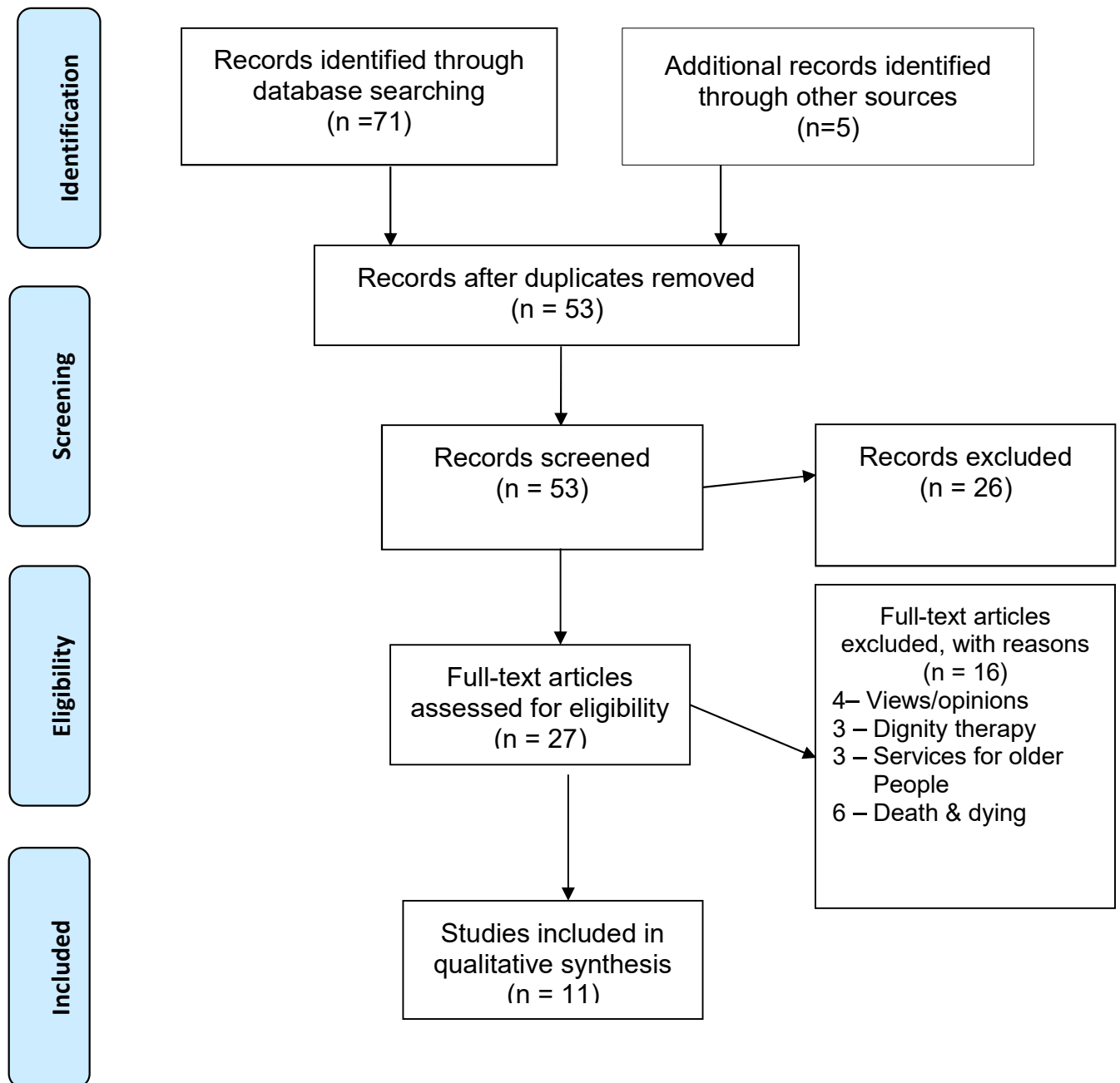
**Table 2.1: Inclusion and exclusion criteria**

<b>Inclusion criteria</b>	<b>Exclusion criteria</b>
Older adults/patients >65 years	Adult patients < 65 years
Research papers published after 2000	Research papers published before 2000
Older people or older patients experiences of dignity	
Health care professionals' experiences of dignity (nurses, health care support workers)	Doctors' perceptions and experiences of dignity

As well as searching published research literature, key documents, policies and initiatives produced by the government and agencies such as Age UK were also reviewed. The search strategy, evidence selection and appraisal process is provided in appendix A. The summary of the selected studies for review is included in Appendix B. The procedure of evidence selection and exclusion was

recorded on a 'Preferred Reporting Items for Systematic Reviews and Meta-Analyses' (PRISMA) flow chart as shown below.

PRISMA flow diagram of the literature screening process



Studies directly exploring emergency care nurses or older people's experiences of dignity in emergency care were not found. A number of studies relating to older people's experiences of accessing emergency care and waiting times in ED were found, but were excluded on the basis that they did not reflect the aims of the literature review or the current study.

Empirical literature identified predominantly consisted of qualitative studies, with a very small number of quantitative studies. Ten qualitative studies and a survey that explored older people's, patients' and health professionals' experiences of dignity in a number of care settings were selected. While criteria for assessing quality of quantitative research are well established, there is no consensus on evaluative criteria for qualitative studies (Rolfe 2006). A detailed discussion of the methodological quality, relevance, and credibility of the included studies (Rhoades 2011) is presented in Appendix A and a summary is provided below.

One study (Baillie et al 2009) was a large-scale survey using a questionnaire to capture the views and perceptions of nurses working with older people to illuminate how and why the dignity of older people may be compromised in practice. Surveys are regarded as superior in accessing large numbers of people (Bowling 2009: 215). In nursing research, Parahoo (2014: 282) suggests surveys are very efficient in capturing the beliefs, opinions, perceptions, expectations, experience and behaviour of clients and staff. Over fifty-four per cent of the respondents in this survey worked with older people in a range of roles and organisations (Baillie et al 2009). As a result, the findings provide a great insight into how dignity of older people is promoted or compromised within everyday practice from the perspective of a very large number of the nursing workforce. The other studies (Walsh & Kowanko 2002; Jacelon 2003; Woolhead et al 2004; Bayer et al 2005; Hoy et al 2007; Baillie 2009; Magee et al 2008; Matiti & Trorey 2008; Webster & Bryan 2009; Hall & Hoy 2012) used a number of different approaches such as case study, ethnography, grounded theory and phenomenology to explore older people's



and nurses' experiences of dignity. Gelling (2015) notes that qualitative researchers have a large number of methodological approaches and research tools available to them. Despite this, a number of researchers (Woolhead et al 2004; Bayer et al 2005) did not make explicit the methodologies guiding their studies. This omission can make it very difficult to assess the quality of the study (Polit and Beck 2014: 276). Caelli et al (2003), however, are of the opinion that even if a qualitative study is not guided by an established methodology, good clinical questions can still be addressed.

Qualitative research is an approach to scientific inquiry that allows researchers to explore human experiences in personal and social contexts, and gain greater understanding of the factors influencing these experiences (Gelling 2015). Regardless of lack of information about the methodological approaches utilised, the findings from the studies provided a rich description of dignity and care practices that either promoted or compromised dignity in a variety of care settings from older people's, patients' and nurses' perspectives. In assessing rigour of qualitative studies, a number of researchers addressed this within the research reports. This included strategies such as reflexivity, audit trail, data triangulation and member checking. Findings were described in greater detail within all the studies, with the emphasis on providing a 'thick description' of dignity. As Sandelowski (1986) observes, a qualitative study is credible when it presents such an accurate description or interpretation of human experience that people who also share that experience would immediately recognise the descriptions. In all the studies reviewed, older people, patients and health care practitioners were able to describe situations or practices that either compromised or promoted patient dignity in health care environments such as medical, surgical, geriatric wards, and care homes. All participants (patients, older people, nurses and health care support workers) associated dignity with characteristics that included privacy of the body, confidentiality, respect and autonomy. Several other factors, such as the physical care environment, management pressures and how care activities are conducted, were also found

to impact on the dignity of older people. The themes to emerge from the literature are presented as a narrative review in the next section.

### **Privacy and Confidentiality in the Care Environment**

It is generally accepted that in a democratic society every citizen needs some privacy; this is considered a basic human right, and a degree of privacy is essential for physical, mental, emotional and spiritual being (Woogara 2001). Patient care is characterised by vulnerable and intimate situations when a health care practitioner may invade the patient's privacy (Back & Wikbald 1998). When patients are admitted to hospital, it is expected that their privacy will be respected and protected but this privacy can take different forms (Woogara 2001), such as privacy of the body or space. Confidentiality is also a form of privacy where precautions must be taken to prevent information being shared inappropriately during nursing hand-over and consultant ward rounds.

The NMC (2015: 6) Code of Professional Standards stipulates that when providing care, nurses must respect people's right to privacy and confidentiality. Privacy of the body was a central theme in the nurses' accounts of promoting dignity in several studies (Walsh & Kowanko 2002; Baillie 2009; Matiti & Trorey 2008). Nurses' spoke of the importance of screening the bed area while performing procedures and covering the parts of the patient's body that did not need to be exposed while washing the patient or performing other aspects of care. Recognising the patients' need to be protected from the unnecessary gaze of others was an aspect considered to promote dignity by the nurse participants in Walsh and Kowanko's study (2002). Baillie (2009) reported how nurses ensured patients' dignity by covering their bodies: *'You should never expose any more of the body than absolutely necessary when carrying out care'*.

Patient participants involved in the studies reported that nurses made an effort to draw curtains around them when carrying out certain procedures such as washing and bathing. However, curtains were badly fitted or transparent and

staff did not request permission to enter closed curtains. Patients reported these factors violated their dignity as their naked bodies were exposed to strangers. As one participant highlighted in Matiti and Trorey's (2008) study: *"Even if curtains are closed sometimes people come in and out - for example nurses looking for colleagues"*.

For older participants, privacy of the body was seen as an important constituent of dignity (Matiti & Trorey 2008; Webster & Bryan 2009). Older participants in general felt satisfied with the level of care they received during hospital admission, but were keen to discuss issues around promotion of dignity in relation to privacy of the body (Webster & Bryan 2009). Several studies (Walsh & Kowanko 2002; Baillie 2009; Hoy et al 2007; Magee et al 2008; Matiti & Trorey 2008) further reported the exposure of the body as a central concern of dignity. The biggest concern was over the use of hospital clothing, especially ill-fitting pyjamas, theatre gowns and garments with slits at the back. This was mentioned by patients and older people in several studies (Walsh & Kowanko 2002; Woolhead et al 2004; Baillie 2009; Matiti & Trorey 2008).

The majority of older participants in all the studies reported feeling undignified when they had to wear hospital gowns. They describe feeling like 'fools' and 'dehumanised' in the gowns (Woogara 2005). Nurse participants in several studies reported that patient dignity was closely related to the way the patient was dressed and the nature of the clothing they were required to wear (Hoy et al 2007; Walsh & Kowanko 2002; Baillie 2009; Hall & Hoy 2012). Hospital gowns made the older people appear passive and 'seen as diagnoses' instead of unique individuals (Hall & Hoy 2012). Hospital gowns were not designed for use in wards. They were designed for use in the operating theatres (Woogara 2005), but it is regular practice for all patients admitted to hospital to wear the gowns whilst being examined or awaiting examination by the medical practitioners. In fact, it is a common nursing practice in some care settings, especially in ED, that on arrival at hospital all patients are stripped of their

clothing and are dressed in hospital gowns. Baillie (2009) further reported that on surgical wards, where patients had invasive devices attached (such as catheters, intravenous infusion) patients were not fully dressed and were generally wearing hospital gowns. This can be seen as a compromise of patient dignity. Nonetheless, many nurses recognise this and feel hospital gowns make patients anonymous.

Studies by Hoy et al (2007) and Hall & Hoy (2012) found that nurses would prefer older people to wear their own clothes when in hospital as it facilitated a person's self-esteem. When dressed in their own cloths, the patients were able to make the nurses see the person behind the diagnosis. This was also important to a number of older participants in several studies (Woolhead et al 2004; Matiti & Trorey 2008; Baillie 2009). They identified looking respectable as important in maintaining their dignity. They stated that lack of attention paid by hospital staff to their appearance, such as haphazard buttoning of clothes or dishevelled dress, reduced dignity. Most participants wanted to wear their own clothing, jewellery and other personal items (Matiti & Trorey 2008). Being dressed appropriately was seen to promote dignity.

Several older participants in other studies (Webster & Bryan 2009; Woolhead et al 2004) reported that nurses did their utmost to maintain their dignity. Dignity was seen to be maintained when nurses reduced exposure of the body by covering patients with towels, and drawing curtains around beds when carrying out physical care procedures. Privacy does not only mean exposing one's body to the gaze of others. According to the NMC Code of Professional Standards (2015: 6), nurses must protect the confidentiality of patients and clients in their care and they must make sure information about them is shared appropriately. As a result, precautions must be taken to prevent information being shared inappropriately and that procedures are in place for sending or receiving patient information, for example, hand-over procedures, senior doctor ward rounds or teaching rounds. Providing care involves information sharing as well as

delivering physical and psychological care, all of which have implications for older patients' privacy (Birrell et al 2006). Nevertheless, the respect for people's rights to privacy and confidentiality is not always maintained in care settings. Evidence suggests that older patients being cared for in settings where there are bays rather than separate rooms experience little privacy in relation to their personal information. Information about their condition is shared without their consent during consultant ward rounds, or other interactions between staff and patients (Woogara 2005). What is more, nurses often infringed patients' confidentiality at the nurses' desk by talking about patients with each other: *'Some nurses discuss patients at the nurses' desk. I hear these things because my bed is near the desk'* (Matiti & Trorey 2008).

This information further becomes public knowledge to anyone else in the bay or nearby. While within bays, bed curtains provide visual privacy, many nurses and older participants felt this offered limited auditory privacy (Jacelon 2003; Baillie 2009; Matiti & Trorey 2008). Privacy of information, especially having regards for patients' right to confidentiality, was perceived in several studies, by patient participants as an integral part of maintaining dignity (Walsh & Kowanko 2002; Jacelon 2003; Baillie 2009; Matiti & Trorey 2008). Older participants support the view that privacy and confidentiality are important components of dignity and integral to its promotion (Webster & Bryan 2009; Jacelon 2003; Walsh & Kowanko 2002; Matiti & Trorey 2008). Although nurses try to maintain patients' privacy and confidentiality, patient dignity is often compromised due to environmental factors such as ward layout and poorly fitting curtains (Jacelon 2003; Baillie 2009; Matiti & Trorey 2008; Baillie et al 2009). Nurses' indiscreet actions, such as discussing patient details at nurses' desks, are a further reminder that confidentiality is frequently breached, however unwittingly, during the course of daily nursing practice (Matiti & Trorey 2008).

### **Physical Care Environment, Work Pressures and Management Support**

The Royal College of Nursing's survey using a questionnaire with fixed and free text questions distributed to RCN members via email link, to gain their perspectives on dignity in practice (Baillie et al 2009) had the largest sample size compared with other studies included within the review (Baillie 2009; Webster & Bryan 2009; Walsh & Kowanko 2002; Jacelon 2004; Hoy et al 2007). The sample size consisted of large number of healthcare practitioners working with older people in a variety of healthcare settings. Those respondents who worked with older people reported that physical environments where inadequate facilities, such as only three toilets for twenty-two patients and limited bed space, were not ideal environments in promoting older patients' dignity. While the physical environment had an important effect on dignity, the employing organisation was also reported to be influential. Respondents felt that the managerial ethos, leadership, bed management, staffing time and workload were also important in maintaining dignity (Baillie et al 2009). A number of respondents reported that NHS targets, unsupportive management and budgetary pressures were barriers to dignified care (Baillie et al 2009). This survey provided key insights into the challenges healthcare practitioners faced in maintaining older people's dignity in care environments. Several constraints which were out of the respondents' control impacted upon delivering dignified care. Similar to other studies included in the review (Walsh & Kowanko 2002; Webster & Bryan 2009), respondents in this survey also reported that respecting older patients' privacy and confidentiality were important components of dignity (Baillie et al 2009).

### **Showing Respect, Being Recognised as an Individual and Communication**

A number of studies also reported that ageism continued to be evident in healthcare settings and contributed to lack of respect (Woolhead et al 2004; Webster & Bryan 2009). Respect was the most commonly used term relating to behaviours associated with dignity and widely expressed by healthcare practitioners and patient participants in several studies (Walsh & Kowanko

2002; Bayer et al 2005; Matiti & Trorey 2008). Many older participants reported that visible signs of ageing lead to disrespect from others. For example, grey hair made people feel anonymous, or treated as a child. Participants mentioned disrespectful labels attached to old age such as '*cotton buds*', '*wrinkles*', '*bed blocker*', and '*geriatrics*' (Woolhead et al 2004; Webster & Bryan 2009).

Older people want to be perceived as people of value, to have their innate individuality recognised and be treated with respect (Webster & Bryan 2009; Kowanko & Walsh 2002; Woolhead et al 2004). Forms of address were seen as either enhancing or jeopardising dignity. Several older participants reported feeling patronised when being called 'love' or dear' and the use of Christian names was seen as disrespectful, intrusive and very offensive (Woolhead et al 2004; Matiti & Trorey 2008; Webster & Bryan 2009).

Respect is concerned with paying attention, recognising and considering the needs of individual patients (Matiti & Trorey 2008). Older participants further emphasised that fundamental to experiencing dignity was being shown respect by others and having respect for oneself (Bayer et al 2005; Baillie 2009). Older people are in frequent contact with health care workers who have a tremendous impact on their dignity (Jacelon et al 2004). For many nurses, respect appears to mean treating a person with due regard for their personhood, for example, the nature of the person, their feelings, their individuality and their wishes (Walsh & Kowanko 2002; Baillie 2009; Hall & Hoy 2012). Likewise, in care settings patients expect nurses to be their advocates at the time of vulnerability, accepting them as equal human beings with absolute value and individuality (Matiti & Trorey 2008).

The NMC's (2015: 4) Code of Professional Standards also affirms that all people are treated as individuals, recognising their diversity and individual choice. The NMC (2009: 31) *Guidance for the Care of Older People* further state that nurses "*Must demonstrate a personal and professional commitment to equality and diversity*". Despite the emphasis in key documents such as the

NMC and NSF for older people (DOH 2001) on promoting diversity, very little research was identified that explored experiences of older people from ethnic minority communities. Two studies reviewed (Woolhead et al 2004; Magee et al 2008) included older participants from these communities. Woolhead et al's (2004) study included five participants who were Afro-Caribbean and Asian. Similarly, Magee et al (2008) also report six Asian participants from a sample size of thirty-five participants. Other studies did not reflect the local population, as no participants from ethnic minority communities were included.

Communication is one of a nurse's most essential skills and is not only about the spoken word, but also body language and non-verbal cues (NMC 2009). Some older participants reported that health care practitioners sometimes talked about them in their presence as if they were not there (Magee et al 2008; Woolhead et al 2004)). Older participants in Webster and Bryan's (2009) study felt that effective communication was an important element of respect and were able to describe situations where staff listened and were friendly and approachable. Similarly, Bayer et al (2005) also reported that participants felt their dignity was enhanced when they were spoken to with kindness, politeness and were listened to. Nevertheless, some participants in Matiti and Trorey's (2008) study reported that communication was merely task-orientated and they felt uncomfortable when nurses did not make eye contact with them when carrying out procedures like bed bathing, as this tended to increase their discomfort. To promote dignity in all care settings, communication should be tailored to individual needs, taking into account patients' feelings, communication difficulties or impaired cognition (Bridges and Nugus 2010).

### **Autonomy, Independence and Choice**

Independence and autonomy were considered by older participants to be major concerns associated with maintaining dignity. Many of them reported wanting to remain independent, have control over their lives for as long as possible; maintain their mental/thinking ability and the opportunity to make some choices



about their care (Woolhead et al 2004; Baillie 2009; Matiti & Trorey 2008). Participants felt that they were seldom given an opportunity to participate in discussions and policies directly affecting their lives or their well beings (Bayer et al 2005). Dignity was enhanced when they were actively encouraged to participate in the decision-making process (Bayer et al 2005), which gave them freedom of choice (Woolhead et al 2004), and independence (Webster & Bryan 2009). Loss of independence and control over what was happening to them was seen as factors that compromised their dignity (Webster & Bryan 2009; Woolhead et al 2005; Baillie 2009).

A study that sought nurses' perceptions of dignity reported that nurses felt they were patient's advocates in maintaining dignity in circumstances where the patient could not or would not do so for themselves (Walsh & Kowanko 2002). Several studies also reported that when older people experienced loss of independence or control due to illness, their dignity was maintained because health care practitioners demonstrated an understanding of their needs, especially privacy and choice (Webster & Bryan 2009; Woolhead et al 2004). For those who were less independent, choice was viewed as facilitating their independence and involvement in the care received. A simple choice of taking a tablet with or without water was viewed as very positive and perceived as helping to maintain dignity by a participant in Webster & Bryan's (2009) study: *"The staff nurse...she'd say you take that aspirin, do you like it in water or do you take it as it is, oh very caring in that way, very caring"*.

In the same way, many older participants reported that to promote dignity, reassurance and friendliness from healthcare practitioners were equally important. Interactions that made patients feel in control included explanations and information giving, offering choices, gaining consent and promoting independence (Baillie 2009). Participants also pointed out that if procedures were fully explained, then their embarrassment in care situations was minimised: *"Knowing what to expect, it gives you control and one's dignity is*

*maintained*” (Matiti & Trorey 2008). Older participants in many of the studies (Hoy et al 2007; Matiti & Trorey 2008; Woolhead et al 2004; Walsh & Kowanko 2002) described autonomy, independence, control and the freedom of choice as elements that promote dignity. It was apparent that many older people want the ability to make their own choices in society and in care situations. Supporting them to take part in making care decisions would enable them to express their choice and wishes, thus promoting dignity. Older people need to be involved in making decisions that can affect their life (Cook 2010). This may include small decisions, such as, when to bath or major decisions which may involve medical treatment or preferences about how they want to be cared for and perhaps where they would want to die (NMC 2015). Without being involved in decision making, older people reported feeling invisible and insignificant (Bayer et al 2005).

It is clear that older people have strong views about their right to be consulted in making decisions about their health care. What is more, several participants commented on the importance of being able to make up their own minds and being free to use their own initiatives (Magee et al 2008). More recently the NMC stipulated that nurses must recognise and respect the contribution that people can make to their own health and wellbeing (NMC 2015: 5). However, the NMC also indicated that nurses must also recognise the level of involvement older people want in their health and wellbeing and must respect and support the decisions older people make (NMC 2015: 5). If nurses and older people hold very different views or perceptions of what older patients needs are, then measures that are necessary to respect older patients’ wishes and support their autonomy could be lost (Scott et al 2003).

## **Discussion**

Older people make up the largest single group of patients using the NHS, and healthcare practitioners are highly instrumental in promoting their dignity (Elaswarap 2007). Healthcare practitioners are aware of what constitutes

dignified care and can make a difference in maintaining older people's dignity, an imperative for both healthcare practitioners and older people in all care settings.

Nurses have a professional duty and responsibility to respect patients' dignity in all settings where nursing care is provided. Respect for dignity is a central value within nursing codes. The maintenance of older people's dignity has featured in a number of policies and guidelines in the UK which recommended that nurses provide care that respects the dignity of older people. The NMC's *Guidance for the Care of Older People* encourages nurses to value the older people they care for and promote their well-being (NMC 2009: 9). It emphasises the importance of dignity and respect for older people in all care settings. However, consistently delivering dignified care remains a challenge for nurses, as highlighted in the research literature and recent published reports examining the care and experiences of older people in a variety of hospital settings.

The literature further indicates that healthcare practitioners, especially nurses, have strong views on dignity and understand what dignity means to them. In the literature reviewed nurses described care situations when they felt patient dignity was promoted or compromised. Both older people and healthcare practitioners identified very similar elements associated with dignity. The key elements associated with dignity, such as privacy, respect and autonomy, are also common and core components of professional codes, standards and government policies in the UK. This literature review further highlighted that healthcare practitioners face many challenges in delivering dignified care and have developed ideas and strategies that can promote the dignity of older people. In spite of this, older people's experiences suggest that care that promotes dignity is not always provided. There is a marked difference from older people's perspective, between the rhetoric and reality of dignity in care (Calnan et al 2005). Nonetheless, findings show that both older people and healthcare practitioners in care environments such as medical and surgical

wards appreciate the importance of dignity and identify similar care practices that promote or compromise it. However, most of these studies have been carried out in only a small number of clinical areas.

There is a shortage of studies aimed at determining how the dignity of older people with dementia is promoted or compromised in care settings. The majority of older people with dementia are aged over sixty-five and there is a higher than average risk that they will become physically ill and need treatment in a hospital setting (Archibald 2002 cited in Cunningham and McWilliam 2006) such as the ED. Managing the care of people with dementia is a significant part of the work of most healthcare practitioners and little is known about these challenges and their impact on dignity.

None of the literature has explored older people's or emergency care nurses' experiences of dignity within an emergency care setting, despite the fact that older people, including those with dementia, attend EDs with more emergent and urgent conditions than any other age group (Sherman 2009). The majority of older people admitted to hospital wards come through the ED. More importantly, older people attending the ED come with a multitude of nursing care needs, ranging from minor injuries and illness through to life-threatening conditions (British Geriatric Society 2012). Emergency departments are a key interface in the health and social care system where unwell, older people are assessed, treated or admitted (British Geriatric Society 2012). As within all care settings, nurses and healthcare support workers provide care to the older people in the ED.

While a number of studies have explored healthcare practitioners' experiences of dignity in several care settings, no study was found that investigated the phenomenon of dignity from the ED nurse's perspective. A study exploring nurses' experiences of caring for older people in the emergency care setting to discover their perceptions and views of dignity is imperative and will contribute to the existing body of knowledge relating to the dignity of older people.

The findings from the studies reviewed, not only enhance our understanding of the concept of dignity from the perspectives of older people and nurses, but also contribute to the theoretical background of the current study. The strengths of these studies were that they explored the meaning and experiences of dignity from the perspective of those who had the experience. Most of these studies were qualitative and Green and Thorogood (2014:31) highlight that, qualitative research has a potential role in contributing to the 'evidence base' of nursing as it can answer questions that experimental methods cannot address, such as the meaning or perceptions of dignity experienced by older people or healthcare practitioners.

Kumar (2014: 49) is of the opinion that literature review not only provides a theoretical background to a study, but also acquaints you with the research methodologies that have been used by others to find answers to research questions similar to the one you are investigating. The studies included in this review were guided and framed within a number of well-established qualitative methodologies. The most predominant approach was phenomenology. Phenomenology is an umbrella term encompassing both a philosophy and a range of research approaches (Finlay 2009). Descriptive and interpretive phenomenological approaches are commonly used in nursing research. Common to these approaches is the desire to understand humans from within their own subjective experiences. Both approaches start with the 'lived experience' of the participants and focus initially on individual and unique everyday experiences and concrete examples of the phenomenon to be researched (Holloway & Wheeler 2010: 272).

The traditional data collection strategy for both approaches is the in-depth interview, although some researchers often combine data collection methods such as interviews and observations. This can often lead to methodological inconsistency and is not recommended in phenomenology (Rose et al 1995).

The output of the interview is a narrative account by the participants of their knowledge and experiences related to the topic of study (Lopez & Willis 2004). Two of the primary differences between the descriptive and interpretive approaches lie in how the findings are generated (Lopez & Willis 2004). A key feature of descriptive phenomenology is the belief that researchers must 'bracket' their prior knowledge or experience of the phenomena under study so that fresh impressions could be formed and described about the phenomena without previous influences (Snow 2009; LeVasseur 2003). Whereas in interpretive phenomenology 'bracketing' is seen irrelevant (Finlay 2009) because the researcher is required to have detailed first-hand knowledge on the subject under study in order to provide the interpretation of the experience (Mapp 2008). Thus, the research methodology informed by interpretive phenomenology seeks to reveal and convey deep insights and understanding of the concealed meanings of everyday life experiences (Witt & Ploeg 2006).

Four studies (Walsh & Kowanko 2002; Hoy et al 2007; Matiti & Trorey 2008; Hall & Hoy 2012) used an interpretive phenomenological approach and one was descriptive (Webster & Bryan 2009). The aim of the four interpretive studies was to conceptualize the meaning of dignity from the experiences of older people and nurses. The experiential narratives were analysed and interpreted to provide a symbolic meaning of dignity. In contrast, the descriptive phenomenological study of Webster and Bryan (2009) focused on describing recently hospitalised older people's experiences of dignity. The purpose of this study was to describe their experiences of how dignity was maintained or compromised in hospital rather than to uncover hidden meaning of these experiences.

The potency of these studies lies in the researchers' understanding of the guiding set of philosophical assumptions underpinning the methodologies. Streubert and Carpenter (2011: 24) believe that a thorough understanding of the philosophical assumptions that are foundational to the method is essential, as lack of understanding has the potential to result in misunderstood findings.

Grounded theory was used in two studies (Jacelon 2003; Magee et al 2008). Grounded theory is often viewed as a theoretical position or paradigm or as a method of data analysis. Savin-Baden & Major (2013: 183) view it as a qualitative research approach that explicitly intends to develop theory from the study of cases. Gelling (2014) suggests that grounded theory research involves concurrent data collection and data analysis, resulting in the development of theories rooted in the real world and in the data collected. These theories help to explain how people experience social interactions, which can inform practising nurses and guide them in shaping the social world for the benefit of patients (Gelling 2014).

While a number of well-established qualitative research approaches were evident in the reviewed literature, a case study approach was also used. The last few decades have seen case study as an approach of choice for a number of qualitative researchers (Savin-Baden & Major 2014: 151). In case study research, an issue is explored through one or more cases within a bounded system, such as a ward setting (Creswell 2007: 73). Baillie (2009) explored the meaning of patient dignity, threats to patient dignity, and how dignity can be promoted in the acute hospital setting using a case study design with embedded cases. All these researchers have attempted to understand older peoples and health care professionals' perceptions and understanding of dignity in several health care settings (Morse 1995). However, we still know little about ED nurses' perceptions and understanding of dignity in the emergency care context.

The methodologies utilised within the literature have provided valuable insight and understanding of the research approaches that can be used to answer a question similar to the study presented in this thesis. What was also apparent within the studies was that the research question drives the research, and different methodological approaches are required to answer different types of question (Gelling 2014). All approaches are based on different sets of

philosophical beliefs and have a number of different characteristics. As Creswell (2007: 85) confirms, examining published studies can further enhance our understanding of major characteristics of qualitative research approaches that can be adopted to answer specific questions. This literature review, therefore, not only provided a theoretical background to the current study, but also informed and acquainted the researcher with a number of common research approaches.



## **Chapter 3: Research Methodology and Methods**

### **Introduction**

This chapter presents the research methodology and procedures selected to achieve the aim of this study. This is an exploratory qualitative study using a descriptive phenomenological approach to direct data collection and analysis. In the following sections the rationale for choosing a qualitative methodology and justification for choosing descriptive phenomenology as the framework for guiding the study are discussed. Finally, the methods adopted for data collection and analysis are presented.

### **Research Aim and Objectives**

The literature review presented in the previous chapter identified a gap in the understanding of emergency care nurses' perceptions of older people's dignity in the ED. While there is an abundance of evidence relating to nurses' and older people's perceptions and understanding of dignity from a range of other care settings, there is very little evidence relating to emergency care. As a nurse working in the clinical environment of the ED, the researcher wanted to address this gap by providing an understanding of dignity in the emergency care setting from the perspective of ED nurses providing care to older people.

The majority of older people start their healthcare journey from the ED and it is imperative that dignified care should also start from there. The researcher's beliefs and understanding are that dignity is an essential and unique component of nursing, and promoting older people's dignity is a nursing priority in all care settings, including the ED. Very little is known about ED nurses' perceptions and understanding of older people's dignity and what constitutes dignified care and the factors that can facilitate or hinder its delivery. This study endeavoured to seek out the lived experiences of nurses caring for older people in the ED to describe their in-depth perceptions and understanding of dignity. This was an exploratory study searching depth and understanding of the phenomenon of

dignity from the ED nurse's perspective. Listening to and understanding ED nurses' experiences was the key to the research and underpinned methodological choices. The purpose of the investigation was to describe the experiences of ED nurses as they were presented, without intention to provide theoretical interpretations. The aim of this study therefore was to explore emergency care nurses' experiences of caring for older people in one emergency department of a teaching hospital. Two fundamental objectives of the study were:

- To describe ED nurses' perceptions and understanding of older people's dignity in the emergency department.
- To describe factors that nurses perceive can facilitate or hinder dignified care in the emergency department.

### **Selection of a Research Methodology**

To inform and select the appropriate methodology, a number of research paradigms were considered, namely positivist, post-positivist and interpretive. The positivist paradigm is also called the scientific paradigm and its purpose is to statistically prove or disprove a hypothesis, a proposition of cause and effect (Mack 2010; Grant & Giddings 2002). The positivist paradigm asserts that reality is disciplined, rational and logical, where knowledge is measured objectively and independent of human interactions (Reiners 2012). Research carried out within this paradigm is usually quantitative and includes methods such as experiments and surveys (Mack 2010; Watson 2015). The research is objective, where reality and knowledge created are seen as external to the researcher (De Villiers & Fouch 2015). The key assumptions in relation to clinical nursing research are that the body and body parts are seen as objects and the human patient is viewed as a physical, unthinking entity that can be measured, ordered and manipulated (Allsop 2013: 22). While research within the positivist paradigm has dominated nursing and healthcare research (Polit & Beck 2017: 9), the paradigm has been challenged and criticised as a method for researching human affairs (Mack 2010). Critics of the positivist paradigm argue

that humans are not 'objects', and are subject to social influences on behaviour, feelings, perceptions and understanding (Allsop 2013: 22; Crossan 2003). Positivist research methods such as experiments and surveys are inefficient for measuring life as it is lived, perceived or experienced by the respondents (Allsop 2013: 24). Following such criticisms, a new scientific philosophy emerged: that of the post-positivist paradigm. Post-positivists believe that human behaviour is multidimensional and too variable to determine through a single method of cause and effect correlation, so different strategies and adjustments are necessary to explain social phenomenon (Greenfield et al 2007; Crossan 2003).

This post-positivist shift in thinking facilitated the assimilation of mixed methodology whereby quantitative and qualitative methods can be used together to investigate a particular social phenomenon (Grant & Giddings 2002). Letourneau & Allen (1999) describe this as critical multiplism, meaning that post-positivists still retain many of the positivist beliefs of precision, cause and effect, but can also incorporate a qualitative methodology to understand the subject's experiences or perspectives (Grant & Giddings 2002). The perceived benefits and strengths of mixed method is that it offers the researcher the potential to increase the scope of a study and the validity and accuracy of the findings (Moule et al 2017: 281). Nevertheless, post-positivistic research designs are still considered to be mainly surveys and experiments (Parahoo 2014: 36). In theory, despite some adjustments, the post-positivist paradigm still retains the legacy of positivism, and a hypothetico-deductive component (Parahoo 2014: 36; Bally 2012). Giddings & Grant (2006) further support this thinking and argue that post-positivism is a shift from *within* the positivist paradigm. Adding the prefix 'post' to positivist does not change the original concept or the key philosophical assumption of positivist, it only changes it to a more moderate form (Giddings & Grant 2006).

In contrast, the interpretive paradigm centres on the way in which human beings make sense of their subjective reality and attach meaning to it. This

assumption is rejected by both positivist and post-positivist paradigm (Parahoo 2014: 36). The interpretive paradigm is often called the “anti-positivist” paradigm because it developed due to dissatisfaction with the other two paradigms (Mack 2010; Allsop 2013: 25). The philosophical assumption of the interpretive paradigm is the belief that human behaviour can only be understood from the context in which it takes place and through the eyes of the people’s experience (Parahoo 2014: 37; De Villiers & Fouche 2015). This is further elaborated by Mack (2010) who suggests that research within this paradigm cannot be objectively studied from the outside; instead it is studied from within, through the direct experience of the people. Furthermore, the focus of this paradigm is only on subjective experience, perception, and language which can only be achieved through interaction (Parahoo 2014: 37) and not through experiments or surveys. Researchers within this paradigm seek to understand, rather than explain or statistically prove or disprove hypotheses (Mack 2010). Moreover, in contrast to the other two paradigms discussed, research carried out within the interpretive paradigm is qualitative with the aim of seeing the world through the eyes of the participants, allowing numerous viewpoints of reality (De Villiers & Fouch 2015).

Human dignity is a philosophical notion and a subjective construct, and relates to nursing care provided or the care received. It can only be experienced and described by the individual receiving care or the person providing the care. In this research, it is the nurses providing care to older people every day within the ED who could provide subjective experiences of that care. When considering the positivist paradigm, it was clear that the phenomenon of human dignity could not be understood using quantitative statistical measurements of positivism. Similarly, the post-positivist paradigm further seeks objective knowledge; even in its moderate form it would not fully allow the phenomenon of dignity to be studied subjectively (Weaver & Olson 2006). For this study, it was important to achieve an in-depth understanding of ED nurses’ experiences and views of dignity. The phenomenon of dignity can only be discovered through their experiences in their lived situation within the ED (Weaver & Olson

2006). The research aim and objectives were therefore congruent with the interpretive paradigm and qualitative research.

Qualitative research is used to explore human experiences by using non-quantitative methods of data collection and analysis. Parahoo (2014: 56) believes that the “*Essential distinguishing feature of qualitative research approach is exploration, as a means to understanding the perceptions and actions of the participants from their perspectives*”. The purpose of this exploratory study was to gain ED nurses’ in-depth perceptions and understanding of older people’s dignity and factors that can facilitate or hinder dignified care in the ED. Baker et al (1992) advocate that exploratory qualitative research is typically useful when there is little known about a research topic and or where existing research on the topic is confusing or not moving forward. Driessnack et al (2007) further emphasises that qualitative exploration can be used to gain new insights into previously researched phenomena, groups, experiences or concepts. In this case, even though there is comprehensive literature relating to older people’s dignity in several health care settings, it has not been explored from ED nurses’ perspectives. The aims and objectives of this study were directed at exploring the unique experiences of ED nurses to discover and understand their perceptions of the phenomenon of dignity through learning about their experiences and perspective and the world in which they work (Ritchie et al 2013: 4; Holloway & Wheeler 2010: 3). Exploratory qualitative research design allows the researcher to engage with the individuals and help them to give detailed accounts of their experiences as freely as possible so that the phenomenon, in this case, dignity, could be understood and described as perceived by them (Newell & Burnard 2011: 37; Holloway & Wheeler 2011: 3).

Different paradigms naturally hold opposing ontological and epistemological positions which mean they have different assumptions of reality (ontology) and knowledge (epistemology) that underpin their research methods (De Villiers &

Fouche 2015). What constitutes dignified care is an individual experience and subject to individual perceptions, views and experiences. Ontologically, the experience of caring for older people will be different for each individual ED nurse. The ED is a unique care environment where care is provided to patients in a number of different areas according to their clinical condition or diagnosis. Epistemologically, each study participant would have constructed a set of unique viewpoints and perspectives of older people's dignity and what constitutes dignified care as seen, heard and perceived by them. The researcher needs to engage with the participants to enable them to describe their practice experiences in order to reveal their understanding of dignity as experienced by them.

Depending on the focus of the research, its question and proposed participants, several different methodological approaches are available (Gelling 2015). Ethnography and phenomenology, both located within the interpretive paradigm (Higginbottom 2011) and two of the most commonly used qualitative methodological approaches in nursing and health care research, were considered to address the research question and objectives.

Ethnography is regarded as in-depth study of cultures and cultural groups (Gelling 2015; Newell & Burnard 2011: 98). While ethnography is significantly associated with studying culture, the word 'culture' can be defined in many ways, for example a group of nurses in a particular care setting in the NHS or older patients in nursing homes (Driessnack et al 20007). Holloway and Todres (2010: 170) emphasise that specific nursing settings, situations, rituals, rules and interactions can be studied through ethnography. Ethnography has been applied to study and describe patients' experiences of illness, nursing activities, beliefs and behaviour in diverse aspects of nursing practices and care settings, such as surgical wards or clinics (Oliffe 2005; Cruze & Higginbottom 2013).

The use of an ethnographic approach in this study would have allowed the researcher to observe and describe how ED nurses as a group, provide

physical nursing care to older people, the strategies they use when working under pressure and how they relate to and interact with the multi-professional ED team members and older patients in their care (Creswell 2007: 69; Moule et al 2017: 157; Parahoo 2014: 245). Ethnography is increasingly popular in nursing research and is useful in observing and describing nursing or patient activities, events and behaviour within a specific setting. Nevertheless, Creswell (2007: 73) advises that researchers must consider, very carefully, if this approach is the most suitable design to study the research problem. He believes that an ethnographic approach is only appropriate if the study aim and objectives are to describe how a particular cultural group works, or to explore their behaviour and issues relating to power, resistance and dominance (Creswell 2007: 70). The aim of the present study was not to observe and describe the ED nurse' behavioural patterns of physical care provided to older people (Robinson 2013) but to explore and describe individual nurses' accounts of their experiences of caring for older people as seen, heard, felt and remembered (Moule et al 2017: 202) in the ED context to discover their perceptions and understanding of dignity. Therefore, ethnography was rejected first on the basis that it would not provide in-depth understanding of the phenomenon under study (in this case dignity) and secondly because of the issues and challenges associated with its observational methods of data collection (Watson et al 2010: 393).

Participant observation, a commonly used method of data collection in ethnography research, involves the researcher actively observing the behaviour, nursing care activities and actions of the participants in the context in which it takes place (Savage 2000; Cruze & Higginbottom 2013). In the current study, the researcher as an experienced emergency care nurse would be involved in observing participants who were known to her in an environment where she works. This posed potential dilemmas for the researcher, namely what is often described as 'reactivity' – the possibility that the researcher's presence can influence the behaviour of the observed (Hughes 2013: 115). The

observer controversy is considered to be extremely problematic, especially when the study is conducted with known participants within the researcher's own workplace; furthermore, a researcher cannot know exactly what the behaviour would have been had the participants not been observed (Watson et al 2010: 392). Even though the researcher is an experienced emergency care nurse and familiar with all care activities associated with emergency nursing, the likelihood of the 'observer effect', if the participants did change or modify their behaviour in any way, it would be difficult to challenge within a busy ED, without disrupting patient care (Hughes 2013: 115) and functioning of the ED. More importantly, if the change in behaviour resulted in poor practice where an older patient's care or safety is compromised in any way, the researcher as a professional nurse would need to intervene immediately.

The NMC's Code of professional standards of practice and behaviour (NMC 2015: 11) stipulates that nurses must protect the safety of the patient and intervene immediately if, a situation, or an incident of poor care practice activity causes harm or potential harm to a patient. In this situation the researcher's role, as that of an observer would have to change to that of a professional nurse bound by her professional code of conduct and if appropriate, formally take action to deal with the incident. The older patient's safety would take precedence over the research objectives and the study would need to be discontinued, and credibility of any previous data collected discredited (Parahoo 2014: 347; Watson et al 2010: 393). Furthermore, this would lead to a source of conflict between the researcher as a nurse and the participants, thus impacting on future working relationships within the ED. As a result of these issues associated with ethnography, phenomenology was favoured as a framework to address the research question.

### **Selecting the 'Right' Approach: Phenomenology**

Phenomenology is a distinct philosophical research approach which emerged in the early part of the 20<sup>th</sup> century and is built on several earlier philosophers



such as Kant who aspired to describe human experience as the compelling point of philosophy (Todres & Holloway 2010: 177). From a philosophical perspective, Pallikkathayil & Morgan (1991) describe phenomenology as: “*A way of viewing ourselves, of viewing others, and of all else that comes in contact with our lives*”. Phenomenology focuses on human experiences, allowing it to be used as a framework to investigate and describe the lived experiences of people (Parahoo 2014: 211; Pringle et al 2011). To understand human behaviour or experience, Gelling (2015) asserts that it must be explored and viewed from the person’s perspective as experienced by him or her. Phenomenological research aims to capture the subjective, ‘insider’ meanings and what that lived experience feels like for that individual (Finlay 2009). A concept or phenomenon as experienced by several individuals can be explored, and studied through such an approach (Crotty 1998: 51). In particular, phenomena that are not well understood and are central to the lived experience of human beings can be investigated. Human beings can be studied and understood from ‘inside’ their personal experience through interactions between the researcher and participants and not through any other rigidly and objectively controlled methods (Todres & Holloway 2010: 177; Reiners 2012).

Within nursing and health research, phenomenology is embraced as an epitome framework, and commonly for studying lived experiences of patients and nurses in different care settings. Nursing is concerned with delivering individualized quality care and understanding people (Reiners 2012) and shares many of its underlying beliefs and values with the school of phenomenology. Nursing involves not only the care of one person, but includes groups, families and institutions (Leininger 1988). The three major concepts of nursing phenomena are the human being, the environment, and health (Parse 1992). Nursing science and education have evolved around and continue to be concerned with human beings and concepts such as human wholeness, and nature of the human-universe relationship (Chan 2002; Parse 1992). The assumptions underlying phenomenology complement the assumptions inherent in the

nursing paradigm (MacKey 2009). Phenomenology and nursing are related through their shared approaches to viewing people as subjective human beings, whose objectives and subjective experiences are meaningful in terms of the context in which they find themselves (Taylor 1993). ED nurses have a wide variety of experience of caring for older patients in ED and a view from their perspective is necessary to discover their understanding and perceptions of dignity (Todres & Holloway 2010: 177; Parahoo 2014: 211). Utilising the phenomenological approach will allow the nurse researcher to explore and describe their experiences of the phenomenon of dignity (Moule et al 2017: 156).

Two common phenomenological approaches are widely used in nursing research, namely: descriptive and interpretive phenomenology (Lopez & Willis 2004). While both approaches use similar data collection methods and result in knowledge that reflects insight into the meaning of the phenomena under study, they differ in aim and how the findings are generated (Penner & McClement 2008; Lopez & Willis 2004), as discussed and compared in the next section.

### Descriptive Phenomenology

Building on the work of earlier philosophers Edmund Husserl (1859-1938), a German philosopher and mathematician, developed descriptive phenomenology (McWilliams 2010:230). Its founding principle is that experience should be examined in the way that it occurs, and in its own terms (Smith et al 2009: 12). Husserl was interested in understanding the meaning of one's lived experience (Vivilaki & Johnson 2008) and his philosophy emphasized descriptions of human experiences (Polit & Beck 2014: 270). He called these everyday experiences the 'lifeworld' or 'lived experiences' (Todres & Holloway 2010: 178). Husserl's primary philosophical focus was on the nature and origins of all knowledge and suggested that phenomena cannot be separated from experience and the way to understand phenomena was through in-depth descriptions by those experiencing the phenomena (Dinkel 2005). He viewed human experience as meaningful and interesting because in his view people

are conscious of the particularities of their existence and can articulate them. He further believed that subjective information should be important to scientists seeking to understand human motivation because human actions are influenced by what people perceive to be real (Lopez & Willis 2004). He acknowledged phenomenology as a rigorous scientific approach to investigation.

The main assumption underlying Husserl's approach to the study of human consciousness is that there are features to any lived experience that are common to all persons who have the experience. For the description of the lived experience to be considered a science, commonalities in the experience of the participants must be identified, so that a generalized description is possible (Lopez & Willis 2004). The goal of descriptive phenomenology is the careful description of the phenomenon as experienced by people which include seeing, hearing, feeling, remembering, deciding, evaluating, and acting (Polit & Beck 2017: 471). This description of the phenomenon is described as accurately as possible, refraining from any interpretation. In order to fully explore and describe these essential lived experiences, Husserl advocated that the researcher must actively strip away any previous experiences, preconceptions, opinions or prejudices of the phenomenon under study so that it could be seen clearly with freshness and without any presumptions (Lopez & Willis 2004; Converse 2012; Mapp 2008). He invented phenomenological reduction or bracketing as a method of suspending all previous experiences and preconceptions (Snow 2009) and this is further discussed later in the chapter.

### Interpretive Phenomenology

Interpretive phenomenology, also known as hermeneutics is associated with the works of Martin Heidegger, who studied and worked under Husserl (Converse 2012). He modified and expanded on Husserl's theories and developed interpretive phenomenology (Lopez & Willis 2004). While he agreed with Husserl that phenomenology is concerned with human experience as it is lived, he did not concur with Husserl's beliefs of just describing the lived experience

as it appeared to the individuals (Racher & Robinson 2002). He believed that lived experience should be interpreted to seek the meanings of our existence in the world or being in the world (Parahoo 2014: 215). This is one of the most distinctive divisions between the two approaches. While Husserl's descriptive approach is concerned with description of the lived experience, Heidegger's interpretive phenomenology is concerned with what that lived experience means to the individuals.

In comparing and the two approaches, it is clear that in descriptive phenomenology, the researcher analyses the descriptions given by participants and divides them into meaning-laden statements, gathering those meanings that are essential to the construct of the phenomenon being studied (Penner & McClement 2008). It does not involve interpretation and the researcher is able to bring to written description the structure of the phenomenon of interest (Penner & McClement 2008). To meaningfully describe the essential structure of the phenomenon, the researcher consciously suspends his or her prior experience and beliefs of the phenomenon under study (Snow 2009). In contrast, Heidegger's interpretive approach goes beyond the description, it involves the researcher immersing in the narratives given by the participants and interpreting the meaning of that experience (Converse 2012). The notion of phenomenological reduction as advocated by Husserl was rejected by Heidegger. He argued that the researcher's previous experiences or preconceptions should not be eliminated or suspended, but instead used to interpret and gain an insight to the meaning of the experience (Balls 2009; Finlay 2009). The focus of interpretive phenomenology, therefore, is to seek the meaning of the participant's experience blended from the researcher's understanding of the phenomenon and participant-generated information (Wonjer & Swanson 2007).

Given the noteworthy differences between the two schools of phenomenology Reiners (2012) suggests that researchers needs to be very careful when

choosing a particular approach. She believes that the choice of approach must be congruent with its underlying philosophical tenets. Lopez & Willis (2004) advocate choosing an approach which will most efficiently accomplish the aim and objectives of the proposed study and add substance to what is already known or not known about the phenomenon of interest. When considering the aim and objectives of the present study it was clear that the researcher is simply seeking to describe the phenomenon of dignity as experienced by the participants, with no intention to immerse in the interpretive exercise to discover the hidden meaning of the experience (Reiners 2012). While the phenomenon of dignity has been studied previously from a number of perspectives, it has not been researched from the ED context. Based on this, descriptive phenomenology as a methodology was selected to achieve the aim of the study.

### **Justification for Descriptive Phenomenology as a Research Methodology**

The focus of this study was to investigate the lived experiences of ED nurses in order to understand their perceptions of older patients' dignity and factors that can facilitate or hinder dignified care. A descriptive phenomenological approach was adopted to explore the lived experiences of ED nurses caring for older patients. Descriptive phenomenology as discussed earlier emphasizes an understanding of the world from the perspective of the individual who is viewing the world; it does not attempt to come to a consensus and an objective 'truth' about how all individuals see the world but it instead gives priority to each person's unique viewpoint of the world (Maltby et al 2010: 50). Descriptive phenomenology is committed to descriptions of experience, not explanation or interpretation and through description phenomenon of dignity can be illuminated (Moustaka 1994:58). Researchers propose that a descriptive phenomenological approach has the potential to generate knowledge for practitioners and patient care from their own clinical practice (Rose et al 1995).

This study involved an emergency department where nurses care for older patients as part of their everyday work and could provide first-hand descriptions

of that experience which is central to understanding the phenomenon of dignity from their perspective. Descriptive phenomenology was identified as the best approach in capturing nurses' experiences to illuminate and describe the concept of dignity and factors that can facilitate or hinder dignified care within the ED context.

As a researcher I wanted to examine ED nurses' everyday experiences to seek a vivid and accurate description (Moustaka 1994: 58) of dignity as related to older patients in the ED context. The descriptions of ED nurses' experiences were the focus, as it was through them that an understanding of dignity and factors that can facilitate or hinder dignified care within the ED environment would emerge. In utilizing a descriptive phenomenological approach to knowledge development it will most effectively achieve the aim of this inquiry and contribute to what is already known and not known about older people's dignity in the ED context (Lopez & Willis 2004). This approach is most appropriate when the aim of the research is to understand an experience from the perspective of those involved, to begin accumulating evidence when little is known about a particular area or when studying a phenomenon from a fresh perspective (Swanson 2006:140).

The aim of this study was to describe the essential feature of ED nurses' experiences of dignity within the emergency care setting. In order to arrive at this description of dignity, three overarching principles or steps in congruence with descriptive phenomenology were embedded into the study: phenomenological reduction, analysing and describing (Wonjer & Swanson 2007; Savin-Baden & Major: 2013: 216). Phenomenological reduction requires that the researcher brackets previous experience and knowledge of the phenomenon under investigation in order to take a fresh view of it. Once reduction is achieved, data must be rigorously collected and analysed. Finally, the phenomenon under investigation is described as it appears (Baker et al 1992).

### **Phenomenological Reduction**

An important component of descriptive phenomenology is the belief that it is essential for the researcher to shed all prior personal knowledge to grasp the essential lived experiences of those being studied (Lopez and Willis (2004). The researcher's previous knowledge can minimize the ability to research the topic thoroughly. Unconsciously the researcher may bring assumptions about the topic into the research process and therefore may not be as open to understandings and meaning that participants bring (Hamill & Sinclair 2010). Husserl devised phenomenological reduction or bracketing as a technique to hold subjective, experiences, assumptions and beliefs in abeyance and allow the essence of the phenomena to emerge (Racher & Robinson 2003). By bracketing, prior experience, the researcher can temporarily suspend what she knows already and actively listen to participants and their individual reality (Hamill & Sinclair 2010).

It was an inherent issue for me as an experienced emergency care nurse that I was not only attempting to conduct a phenomenological study exploring the lived experiences of other ED nurses but also in my workplace (Chan et Al 2013). I was aware that my foreknowledge and suppositions had the potential to limit my understanding of the participants' perspective as I already knew something about the phenomenon, in this case, dignity (Chan et al 2013). Consequently, this could introduce bias into the research process whereby the true 'essence' or meaning of the phenomenon (dignity) could be lost. As researchers are human beings, it is natural that they will bring their own personal experiences, preconceptions, beliefs and attitudes to the research situation (Wall et al 2005). In line with the descriptive phenomenological research approach, it was these personal experiences that required exploring and holding in abeyance, so that the phenomenon of dignity was identified and presented from the ED participants' perspectives and not from the researcher's perspective. Wall et al (2005) advocate:

*“It is the personal experiences, preconceptions, beliefs and attitudes that the researcher must strive to expose and hold in abeyance. This helps the phenomenon to be presented from the participant to the researcher’s consciousness in a clear and unaltered manner, exactly as the participant experiences it, before it is subjected to the attitudes and experiences of the researcher. If this can be achieved, then the findings are more likely to be true mirror image of the experience from the participants’ point of view”.*

While it was clear that it is the researcher who brackets her previous experiences and assumptions, there is debate within the literature as to when and how this should be achieved. Drew (2004) argues that bracketing should only be done in the analysis phase of the research. In contrast, others suggest that bracketing should be considered throughout the entire research process (Hamill & Sinclair 2010; Chan et al 2013). Bracketing for me occurred at the start of the research process, when the project was first conceptualized and was an ongoing process throughout the research endeavour (Tufford & Newman 2010). A number of strategies for achieving bracketing in descriptive phenomenology research include keeping a reflective journal to document thoughts, feelings and perceptions throughout the research (Hamill & Sinclair 2010). Gearing (2004) outlines a typology of six distinct forms of bracketing of which one of them is reflexive bracketing. Reflexive bracketing described by Gearing (2004), requires the researcher to develop a ‘thoughtful, conscious self-awareness’ (Finlay 2002), with the intent to bracket out his or her suppositions, ideas and experiences of the phenomenon being investigated. This potentially allows the researcher to reduce the influence of his or her lived experience on the research process.

Dowling (2007) suggests bracketing interviews, where the researcher engages with an academic supervisor in a series of taped interviews through which she can identify assumptions and past experiences in order to ‘bracket’.



The notion of bracketing interviews was discussed with my director of studies at the initiation of the study process. However, this strategy was not considered ideal by my director of studies. No matter which strategy is employed to achieve 'bracketing', ultimately reflexivity is the key thinking activity that helps the researcher to identify the potential influence throughout the research process (Chan et al 2013). Any form of bracketing, whether it is 'bracketing interviews' or keeping a reflexive journal is employed to meet the needs of reflexivity. Reflexivity refers to the engagement by the qualitative researcher in continuous self-critique and self-appraisal and the provision of an explanation of how her own experiences did or did not influence the stages of the research process (Dowling 2007).

I used a reflective journal to write down my thoughts, feelings and perceptions throughout the entire research process. The reflective journal was a crucial tool in this study and served not only to enable bracketing but also to demonstrate transparency concerning issues relating to 'insider research' which had the potential to impact on the study. Appendix H presents my personal perspectives, issues and challenges associated with this study and how the reflective journal enabled the continuing self-reflect in an effort to maintain objectivity. This is not intended to provide my confessional personal experiences, but to demonstrate a methodological and theoretical appreciation, openness and a truly honest awareness of issues and concerns relating to the research (Lambert et al 2010).

As part of the of the bracketing process several scholars of descriptive phenomenology recommend withholding literature review until after data collection (Wojnar & Swanson 2007; Hamill & Sinclair 2010; Lopez & Willis 2004). Postponing literature review is less likely to introduce researcher biases on the research process (Streubert & Carpenter 2011: 92). However, it was not possible to postpone the literature review for reasons already explained in chapter two.

## Methods and Data Analysis

This section presents the process of participant selection, recruitment and methods of data collection and analysis situated within the descriptive phenomenology framework. Ethical review and potential ethical concerns are also highlighted and reported.

### Participants

The data required for this phenomenological study had to be gathered from individuals who had experiences of the phenomenon (dignity) being investigated and could give examples of experience they had personally lived through (Creswell 2007: 61; Todres & Holloway 2010: 183). For this study the participants had to be emergency care nurses who had experiences of caring for older people in the ED. Moustakas (1994: 107) also draws similar distinctions and believes essential criteria for participant selection should be that: *“The research participant has experienced the phenomenon and is willing to participate in the study”*.

Purposive sampling was chosen to select those participants (ED nurses) who had experience of caring for older people in the ED. Patton (2002:230) highlights the relevance of a purposive sampling strategy:

*“The logic and power of purposeful sampling lie in selecting information-rich cases for study in depth. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the inquiry, thus the term purposeful sampling”*.

Purposive sampling is most commonly used in phenomenological studies (Streubert & Carpenter 2011: 90). Drawing upon the recommendations of these experts (Moustakas 1994; Streubert & Carpenter 2011; Patton 2002; Polit & Beck 2014), including Husserl, a set of participant selection criteria was established and assisted in identifying ‘information-rich’ ED nurses. The following selection criteria were used:

- Participants must have had experience of caring for older people in all areas of the ED.
- Participants must be currently working in the ED.
- Participants must be willing to share their experiences and be willing to be interviewed face-to-face at least once for approximately 1 hour.

Information-rich nurses considered for this study had to have had experience of working and caring for older people in all areas of the ED and could provide in-depth personal accounts of their experiences (Todres and Holloway 2010: 183). There are several areas within the ED where patients are seen and treated according to their clinical needs. In the minor's areas of the ED, for example, adult patients with minor injuries and illness are seen. Here, almost all patients are usually well, mobile and very rarely require admission to hospital. In the major's area, however, patients who are very unwell and often require admission to hospital are seen. The resuscitation area of the ED is an area where patients who are critically ill, need invasive monitoring, and require one-to-one nursing are seen and treated. Patients who have been involved in trauma, such as serious road traffic accidents are also seen and treated in this area. Nurses who were newly qualified and were new to working in ED were excluded on the grounds that they would not have had adequate exposure, experience or understanding of working in all areas of the emergency environment and would therefore be unable to provide in-depth examples of their personal experiences to reveal the essential structure of the phenomenon (dignity) under study.

Even though sampling strategy is regarded as a crucial part of phenomenological research, the setting in which the researcher will expect to find the participants is equally important. The research site from where the participants are selected has to be suitable and intimately known to the researcher (Houser 2008; Holloway and Wheeler 2010: 47).

### **Study Site**

The site chosen for this research study was a large emergency department of a teaching hospital which sees and treats over 150,000 patients per year. Over seventy-five qualified nurses' work in all areas of this ED. For a phenomenological study, the participants could be located at a single site providing they have all experienced the phenomenon being explored and can articulate their lived experience (Creswell 2007: 119). This ED was considered to be an appropriate site for data collection because it had a large number of potentially suitable experienced emergency care nurses for participant selection and because of the researcher's intimate knowledge of it due to it being her own place of work. Nevertheless, Creswell (2007: 122) and others (Savin-Baden & Major 2013: 343; Holloway & Wheeler 2010: 65) advocate caution on carrying out research in one's own work setting. While there were a number of advantages of conducting research here, ethical issues such as access, recruitment, and power imbalance between the researcher and participants were potential factors of insider research. These are discussed and described in detail through 'reflexivity' in Appendix H.

### **Access and Recruitment**

Prior to participant recruitment, permission to conduct the study was gained from the hospital's director of nursing. Access was further negotiated in writing from the emergency department's clinical director, general manager and matron (appendix C). Recruitment for the study took place in the ED. A flyer with information about the study was placed in the staff recreation room (coffee room) inviting participants to contact the researcher if they were interested in the study. The flyer generated interest among the potential participants and a number of ED nurses spoke to me in person. Those who expressed interest were given verbal and written information regarding the aims of the research, data collection and analysis, and dissemination of findings. This gave them the opportunity to discuss any questions they had about the research and make a decision about participation. Those who met the selection criteria were invited to

participate in the study. These included nurses with various years of ED nursing experience who held different roles and responsibilities within the department.

### **Sample Size**

Sample size is not an intrinsic feature of qualitative research and there is very little guidance on the appropriate sample size (Proctor, Allan & Lacey 2010: 142). Generally, qualitative sampling consists of small sampling units studied in depth (Holloway & Wheeler 2010: 145). As qualitative studies generate extensive amounts of data, Onwuegbuze and Leech (2007) opine that a large sample size may make it difficult to extract thick, rich data to achieve the study aim. Patton (2002: 244) further notes that sample size depends on the aim and purpose of the research. He emphasizes that in-depth information from a small number of participants can be very valuable, especially if the cases are information rich. Another frequently cited measure of sample size adequacy in qualitative studies is data saturation (O'Reilly & Kiyimba 2015: 81). Data saturation is understood to mean that sampling should continue until no new information is obtained and redundancy is achieved (Polit & Beck 2014: 286). While the concept of saturation has become embedded in the methodological cultural discourses, in reality it is regarded as problematic and potentially limitless (O'Reilly & Kiyimba 2015: 81). Several researchers highlight that data saturation is difficult to achieve due to a number of factors (Polit & Beck 2014: 286; Holloway & Wheeler 2010: 147). No specific rules or guidelines exist pertaining to saturation. Certainly Morse (1995) confirms that frequency, quantity and repetition of ideas in the data do not signify saturation or data adequacy. Researchers must decide for themselves when saturation has been reached (Holloway & Wheeler 2010: 147).

The notion of saturation actually emerged from grounded theory, which advocates simultaneous data collection and analysis with the objective of developing abstracted generalizable theory from individual cases (Charmaz 2006, cited in O'Reilly & Kiyimba 2015: 82). While saturation has become an

essential marker for sampling adequacy for some methodological perspectives, for others, it is wholly inappropriate, and entirely unachievable.

Even if the sample size in a qualitative study is small in compared to others, especially quantitative research, it is regarded to be adequate to achieve the aim and purpose of the research as long as the participants are able to reflect and describe the lived experience. When considering data saturation, the controversy associated with saturation was also debated. In ensuring sampling adequacy, careful choice of sampling, and the cohesiveness of the sample (Morse 1995) were important guiding factors. In this study two principles guided sample selection and sample adequacy as proposed by Creswell (2007: 126) and Polit and Beck (2014: 2). For a phenomenological study, they recommend ten or fewer participants to achieve the study purpose providing, (1) they are carefully chosen to be individuals who have experienced the phenomenon in question and (2) they must be able to reflect and articulate what it is like to have lived the experience. Reflection is an everyday component of nursing. Nurses learn the process of reflection during their training and reflection is encouraged and utilized in practice. Therefore, the participants would be able to reflect and describe their everyday experiences of caring for older people in the ED. Based on the above, ten ED nurses with experience of caring for older people constituted a sufficient sample size for this phenomenological study.

### **Ethical Consideration**

Ethical approval for this study was obtained from the Coventry University Research Ethics Committee and the Research and Development (R&D) office of the Hospital Trust. Guidance was sought from the R&D office on seeking National Health Service Research Ethics Committee (NREC) approval. The R&D office confirmed in writing that the study did not require NREC approval, as no patients were involved. Approval was required only from the R&D office of the hospital where the study was being conducted and this was obtained in writing following submission of the required documents. Appendix D contains all communication relating to this process.

Ethical issues and standards must be critically considered in all research (Streubert and Carpenter 2014: 61). This study explored the concept of dignity from emergency care nurses' perspectives; therefore, a number of specific issues were associated with the research, including the dual role of nurse and researcher, informed consent, confidentiality and anonymity, and research in the researcher's own workplace.

### **Dual Role of Nurse/Researcher**

Holloway and Wheeler (2010:64) observe that nurses often have dual roles and responsibilities: that of a professional nurse and that of a researcher which may be an ethical concern. In this study it was clear that I was not only a researcher but also a nurse who knew and worked with the participants. To explore the subject experiences of ED nurses, the sole method of data collection involved in-depth interviews with the participants. While interviews are commonly used in phenomenological studies, the process is regarded as potentially harmful, especially in nursing where the researcher has a dual role. During interviews, often participants can reveal views, beliefs, attitudes and behaviours that may not only be damaging to themselves but also to others such as colleagues or patients in their care (Parahoo 2014: 35). In effect Tod (2010: 356) points to one significant risk, the likelihood of a staff member describing an incident of negligence, abuse or unlawful activity that may put the patient at physical or emotional harm. The participants in this study care for patients who due to their age and age-related physiological and cognitive changes are often frail and vulnerable (Lovell 2006). Therefore, the key ethical issue for me was: *What if a participant talks about or describes a situation or an incident of unsafe clinical practice or care where he or she was either involved with directly or observed another member of staff that caused harm to the frail and vulnerable older patient in the ED?*

Several researchers (Parahoo 2014: 327; Tod 2010: 356), nonetheless advocate that nurse researchers have to deal with these type of ethical conflicts between their dual roles. They advise that these challenging predicaments must

be carefully considered, pre-empted and if necessary reporting measures put in place and conveyed clearly to the participants prior to interviews taking place.

As a nurse my priority is the safety of the older patient. I also have a professional obligation under the Nursing & Midwifery Council Code of Professional Standards (NMC 2015) to intervene if an unsafe clinical practice or care was disclosed by a participant (McConnell-Henry et al 2009/10).

Nevertheless, the risk-benefit balance of intervening if the participants disclosed unsafe practice had the potential to create a difficult situation between myself as a nurse researcher and the participants ( Tod 2014: 356; Moule et al 2017: 113) which could possibly lead to animosity in working relationships within the ED.

Therefore, it was decided that prior to the start of the interview, I will first reaffirm the aim of the study to ensure participants understanding of what is to be covered in the interview and secondly, inform them that if any disclosure of unsafe practice is made, I will be duty bound to report and discuss this with the appropriate ED manager. Doing this reduces the possible risks and potential conflicts associated with the dual role of a professional nurse and a researcher and a staff member from disclosing an incident of neglect or abuse that could be potentially damaging to themselves and others (Tod 2010: 356).

### **Informed Consent**

Informed consent entails informing the research participants about the overall purpose of the investigation and the main features of the design, as well as of any possible risks and benefits from participation in the project (Kvale & Brinkmann 2009: 70). It also involves obtaining the voluntary participation of the people involved, and informing them of their right to withdraw from the study at any time (Kvale & Brinkmann 2009: 70). Participation in this study was voluntary and ED nurses had the right to ask questions, refuse to give information, and withdraw from the study whenever they wished without penalty. Written information regarding the study, the risks involved and the rights of the participant to participate or not was provided and written consent was obtained. The participant information sheet and consent form are included in Appendix E.



Consent was verified prior to the commencement of the interviews and time allowed for participants to reflect on whether they wished to be involved (Ryan et al 2009). Thus, consent was not a once and forever agreement with the participants but an ongoing process involving every phase of the study (Holloway and Wheeler 2010: 59).

### **Confidentiality**

Confidentiality in research implies that private data identifying the participants will not be disclosed (Kvale & Brinkmann 2009: 70). Participant confidentiality and anonymity in this study was maintained by not using names or any other information that could lead to individuals being identified. During the data collection interviews, participants were not referred to by name at the start, during or end of the interview. Interview transcriptions were also anonymised and each interview was assigned a code number. In addition, interview tapes and transcriptions were stored securely and on password-protected computers (Ryan et al 2009) and only the researcher had access to the data. Other confidential information, such as completed consent forms, transcribed interviews verbatim and tape recording devices were kept in a locked drawer. All research data will be kept for a period of three years in accordance with Coventry University's policy on Principles and Standards of Conduct on the Governance of Applied Research principles.

### **Researcher's Role and Workplace as Context of Study**

The private and intimate nature of the one-to-one interview strategy employed in this study imposed unique constraints and raised distinct ethical issues. I was the tool for data collection (Streubert & Carpenter 2011: 91) and known to the participants as a work colleague. As a result, this raised a number of issues that had the potential to impact on the research, researcher and participants. The issues and challenges associated with 'insider research' are discussed in Appendix H.

### **Data Collection Method**

The main method of data collection was in-depth interviews with the emergency care nurses. The purpose of the interview was not to explain, predict or generate theory, but to understand the participants' shared meaning of dignity by drawing from their lived experience of caring for older patients in the ED, complete with the richness of details and context that shape the experience (Sorrell & Redmond 1995).

### **Justification for In-depth Interviews**

This study was an investigation into human experience. The method for the objective investigation of human experience must be one that remains with human experience as it is experienced and one which tries to sustain contact with experience as it is given and this can only be achieved through the phenomenological method of description (Colaizzi 1978: 53). In order to understand dignity in the ED context, as a researcher, I must first gather from participants their descriptions of their experiences of caring for older patients, as per Colaizzi (1978: 57-58):

*“If I wish to know what a particular phenomenon is, I would first gather from my subjects their descriptions of what their experience is like” (p57-58).*

My epistemological position was that ED nurses have wide variety of experience in caring for older patients and each individual nurse would have mentally created her/his own vision of that experience. These experiences will be enclosed within the perspective of these nurses and I would need to engage with them in collecting the 'essence' of this experience in order to describe this experience as it appears. The aim of this study was to gain an understanding of ED nurses' perceptions of older people's dignity in the emergency care context. To gain access to their experiences and feelings (Fossey et al 2002; Curry et al 2009) in this context, in-depth interviews were chosen as a method of data collection. In-depth interview allows the participants to reflectively recall their experiences with prompting of the researcher to bring to light the meaning of the

experience (Converse 2012). Sandelowski (2000) further supports this and believes that phenomenological interviews are most appropriate because they are typically directed towards discovering the, *who*, *what*, and *where* of events and experiences. Moustakas (1994: 114) also confirms that the in-depth interview is the only method through which data can be generated on the topic and question under study. According to Sorrell & Redmond (1995), the benefit of using in-depth interviews is that they draw from the participants a vivid picture of the experience which leads to understanding shared meanings of the phenomenon under study. This fulfils my study's aim.

### **Interview Design**

In qualitative research, there are several different types of interviews, including unstructured, semi-structured and structured (Baumbusch 2010). Unstructured interview is similar to a conversation, in which the researcher and participant have a topic but no set questions or responses. This type of interview is non-directive and is mostly used to supplement field work observations (Ryan et al 2009). While the unstructured interview may be the gold standard in some phenomenological research, Patton (2002: 342) believes that it requires a greater amount of time and several conversations with the participant to collect relevant information. In contrast, structured interviews are formally constructed and are similar in nature to a questionnaire survey where there are no deviations from the sequence of questions or the language used (Ryan et al 2009). Semi-structured interviews offer a more flexible approach. Here, the researcher can use a series of pre-planned, open-ended questions focusing and framed around the aim of the research study (Donalek 2005). This approach encourages the interview to flow more freely, allows the interviewer to probe or prompt the participants to expand upon specific issues relevant to the research (Newell & Burnard 2011: 76; Baumbusch 2010). Kvale & Brinkmann (2009: 3) describe the semi-structured interview as neither an everyday conversation nor a closed questionnaire. They believe it is a specific approach and a technique which seeks to obtain descriptions of the lived experience.

In deciding upon the approach, it was clear that the structured interview would be too rigid in gathering appropriate data for this study, whereas an unstructured approach would have had the potential to deviate from the focus of the research study (Newell & Burnard 2011: 75). As the lived experience of ED nurses was the central focus, semi-structured interview with an interview guide was the ideal approach.

### **Interview Guide and Questions**

Developing an interview guide is a key to obtaining data that will address the study's purpose and objectives (Ryan et al 2009). Interview guides adopt an informal approach to questioning and allow the researcher to explore, question or query relevant issues. An interview guide with predetermined questions broadly relevant to the study allows the participants to describe their experiences in their own words, provide as much detail as they wish, and offer illustrations and explanation of their experiences. This approach facilitates the collection of richer, more textured data from participants than that obtained from any other approaches (Ryan et al 2009).

An interview guide (see Appendix F) was prepared for this study to ensure that the same basic questions were pursued with each participant interviewed (Patton 2002: 343). The interview guide was developed in relation to the nature of the research and aim of the study (Ryan et al 2009) and provided a framework for the interview process (Patton 20002: 344).

This guide contained very broad and open ended questions to allow the ED nurses to reflect on their experiences. Open-ended questions facilitate the collection of rich data by providing the participants with the opportunity to describe their experience fully (Penner & McClement 2008). Sorrell and Redmond (1995) remark, that if the opening questions are in the 'right region', it elicits a narrative directly related to an important experience of the respondent, who then becomes engrossed in the unfolding narrative. To gain an understanding of ED nurses' perceptions of older people's dignity and to

achieve the purpose of the study, eliciting participants' narratives of their everyday experiences was essential. A number of probes and prompts would be necessary to facilitate conversation, and increase the richness and depth of responses (Patton 2002: 372).

The interview guide was piloted with a nurse colleague working in emergency care in order to check the clarity and appropriateness of the questions and detect any administration problems. A pilot interview can identify if the questions developed to elicit descriptions of phenomena under study are appropriate or need to eliminate or expand (Colaizzi 1978: 58). The pilot interview also gave the researcher the opportunity to assess how the interview went, what did not work, and the opportunity for improvements (Arksey & Knight 1999: 107). Additionally it gave the researcher the chance to practise her interviewing and digital tape recording and transcription skills, as recommended by Balls (2009). A detailed discussion following the interview yielded valuable feedback without prejudice to the research being undertaken (Balls 2009). The interview was digitally recorded and transcribed verbatim. While the pilot interview did not actually raise any potential problems with the questions, upon reflection I did identify areas where I needed to develop my interviewing skills. This included my eagerness to ask the questions quickly, without giving the participant enough time to think and respond. Therefore, I needed to be a better listener, to be more relaxed and to quietly encourage the participants to reflect and describe their experiences rather than being overeager (Balls 2009) to cover the topics on the interview guide. I also transcribed verbatim the pilot interview and discovered that it was an extremely lengthy process as it generated a substantial amount of data. The data obtained from the pilot was not included in the study and was only used to evaluate the interview guide and identify potential administrative problems.

The researcher conducting the interview must have the necessary skills to be able to conduct the interviews (Curry et al 1999). In order to prepare for

conducting the interviews, in conjunction with extensive reading, I also attended a two day qualitative interviewing course at Oxford University prior to data collection.

## **Interviews**

The interviews were accomplished over a period of five months, from April to August 2013, in a quiet room away from the ED in another part of the hospital. This was a neutral location that ensured privacy but was also familiar to the participants (Balls 2009). The participants were given the choice as to where they would prefer to be interviewed. All participants opted to be interviewed at the hospital, but away from their workplace. A mutually convenient date and time for the interviews was arranged.

The interviews were conducted face-to-face using the prepared interview guide and consisted of four phases. The initial phase included a brief introduction to my role as a researcher, introducing the purpose of the research, verifying consent to be interviewed and recording and the interview process and practicalities. It also included general 'chat' about the participant's experience and professional role within the ED. No other demographic information, such as age was obtained. Due to the small sample size I did not want participants to be identifiable and their anonymity and confidentiality breached. The initial stage of the interview was also important because it gave the participants another opportunity to ask questions about the research study (Baumbusch 2010) and clarify any issues or concerns they may have regarding the research or the interviews.

While it was clear that I had a pre-existing professional relationship with the participants, it was still important at this stage of the interview to establish a sense of trust between myself as the researcher and the interviewees. While the one-to-one interviews were social interactions, the relationship between the researcher and the participants was not equal. Therefore, it was of paramount

importance to establish a rapport and trust from the outset to ensure the interview process was successful and minimized any power differentials (Ryan et al 2009; Balls 2009). Balls (2009) advises that to minimize any power differentials, nurse researchers must promote their role as a researcher, rather than their role in the organization, which may be senior or junior to that of the person being interviewed. While one participant was in a senior position to me, others were in junior roles.

In the second stage of the interview, the initial research question was introduced and the participants were asked to reflect and describe their everyday experiences of older people's dignity. The opening question: *"From your experiences of working and caring for older people in the ED, tell me what does dignity means to you?"* set the conversation that encouraged the participants to begin sharing their stories (Sorrell & Redmond 1995).

The third stage of the interview process aimed at exploring participants' perceptions and experiences of factors that can facilitate or hinder dignity during care delivery in the ED context. Questions included: *"From your experiences of caring for older people, can you describe an experience where you felt an older person's dignity was really promoted or hindered?"*

While the established questions were sufficient for participants to start describing their experiences, probes and prompts were used to clarify concepts, meaning of responses and encourage in-depth descriptions (Penner and McClement 2008) of the phenomenon (dignity) under study. In order to seek and uncover deeper understanding of dignity I used probing questions such as *"How did you feel in this situation?"* or *"Why was this so important to you?"* Short and unambiguous questions as prompts were useful in getting the participants to expend on their experiences. Prompts and probing as advocated by Ryan et al (2009) are not only useful in permitting participants to expand on certain issues, but also allows the researcher to draw out more information by requesting the participants to elaborate on a particular issue.

The fourth and final stage of the interview process related to bringing the interview to a close. The interview was closed with the question: "*Is there anything more you would like to tell me?*" Patton (2002: 379) believes this is important in formal interviewing, as it provides the participants an opportunity to have the final say. As a researcher, I expressed my gratitude to the participants for their time, commitment, and contributions to the data collection (Baumbusch 2010). At the close of the interview, a general conversation continued in a more casual way and related to family, children, holidays. Denalek (2005) describes this as a time for more social conversation and a good way for both the researcher and participant to wind down. It was also at this final stage that the participants were asked if they would like to see the transcription of their interviews. None of the participants opted to see and read the verbatim interview transcription. All participants agreed that they would be interested in reading the findings following data analysis.

From the ten interviews conducted, two were rather challenging. One participant, although very enthusiastic in taking part in the study, said everything she wanted to say in the first twenty minutes of the interview. The interview in general proceeded smoothly from question to question. As Kvale & Brinkmann (2009: 165) advises, all participants are different, while some will give short and concise descriptions, other may give long and lively descriptions. What is important is that the data gathered is detailed enough to provide knowledge about the research topic in question (Balls 2009: Kvale & Brinkmann 2009: 165). Even though this interview was the shortest in length, the data gathered was relevant. The other interview related to a member of staff in a senior position to me. I was apprehensive and concerned in relation to disparities of power. In order to mentally prepare for this interview, I reflected on my thoughts, feeling and potential challenges prior to conducting this interview. This is presented and discussed in greater depth in: 'Insider research' in Appendix H.



Each interview lasted on average 40 to 60 minutes. Following each interview, I then took time to stay behind in the room where interviews were conducted to reflect and record my perceptions, feelings and opinions of the interviews in my research diary. I did not take any notes during the interviews as I felt this could be distracting for the participants and may interrupt the free flowing conversation (Kvale & Brinkmann 2009: 179). Therefore, making contextual notes immediately after the interviews while the events and thoughts of the interview process were still fresh in my mind was important (Holloway & Wheeler 2010: 97). In addition, writing down ideas, feelings and issues relating to data collection facilitated and supported the phenomenological reduction (Streubert & Carpenter 2011: 92).

### **Interview Recording**

All interviews were audio-recorded using a small digital tape recorder. Holloway & Wheeler (2010: 94) believe the best form of recording interview data is tape recording. All interviews were recorded inclusive of questions to accurately preserve the participants' words, including tone and pauses (Holloway & Wheeler 2010: 94). Good quality recording of the interviews enabled immediate listening to each interview and transcribing of the recordings (Kvale & Brinkmann 2009: 179). Consent to tape record the interview was obtained from the participants at the start of the interview. This was also made clear within the participant information sheet. No personal information or names were mentioned in the interviews. Each interview was given a number and participants' names and other information was stored in a different place from the tape recordings (Holloway & Wheeler 2010: 96).

### **Organizing the Data**

All interviews were transcribed verbatim by a professional transcriber. The decision to have the interviews transcribed professionally was difficult and required careful consideration. Some authors advocate that researchers themselves should transcribe the interviews, thereby getting 'close' to and

immersing themselves within the data (Balls 2009; Newell & Burnard 2011: 82). In contrast, Kvale and Brinkmann (2009: 180) suggest that transcribing large amounts of interview material is tiresome, time consuming, requires high level of typing skills and is a stressful job. While I was aware that transcribing my own interviews would provide me the opportunity to get immersed in the data (Patton 2002: 440), I did not have the skills to be able to transcribe the large amount of data yielded from the interviews. Each interview produced between four thousand and eight thousand words of narrative data. Upon discussion and debate with my supervisor I opted to have the interviews transcribed. In order to ensure that interviews were transcribed accurately and in detail, the transcriber was instructed to transcribe verbatim word-by-word, retaining all frequent repetitions noting “mh”, “ah” and the like (Kvale & Brinkmann 2009: 181). Newell & Burnard (2011: 82) recommend that if transcriptions are typed by someone other than the researcher, they must be carefully checked. Each transcription was read alongside listening to the recording to confirm accuracy and detail.

### **Data Analysis**

In accordance with the principles of descriptive phenomenology, the participants' recorded narratives were transcribed verbatim and analysed (Hycner 1985). The approach required for data analysis had to be congruent with descriptive phenomenology. Colaizzi's (1978: 59), seven procedural steps for phenomenological data analysis was broadly used to elicit an exhaustive description of ED nurses' understanding and perceptions of dignity. While this strategy includes procedural steps, these steps are by no means definitive and should be regarded as flexible and adaptable by the researcher (Colaizzi 1978: 59). As data analysis in phenomenology is a complex and daunting task, this systematic framework of steps provided guidance.

Data was analysed manually using hard copy of the transcriptions, highlighter pen and then using a Word document on the computer. There are a number of computer programs that can be utilized for data management (Saunders 2003),

such as NVivo and ATLAS.ti. The advantages of such software include creativity, clerical tasks associated with data handling and allowing 'on screen' processes of cutting and pasting instead of spending time cutting and pasting data manually (McLafferty & Farley 2006). While the software packages can be extremely helpful to researchers, there are disadvantages. Learning to use the software can be time consuming. More importantly, conceptualizing data on the computer screen can be difficult, inhibiting visualization and contextualisation (McLafferty & Farley 2006). Due to my limited experiences of using different software, I chose to analysis the data manually and with a Word document. The data analysis process was peer reviewed by one of my academic supervisors. Whiting (2001) suggests that in a descriptive phenomenological study an important and initial aspect of data analysis must begin with the phenomenological reduction or "bracketing". Bracketing involves deliberately examining and suspending as much as possible the researcher's previous experiences and beliefs about the phenomena being investigated (Hycner 1985; Jasper 1994) so that the phenomenon being investigated is seen and examined from the participant's perspective. Hallett (1995) argued that bracketing is a process of mental reasoning rather than paper- or computer-based. Bracketing or phenomenological reduction for this study was achieved by keeping a reflective journal and was an ongoing process throughout the study process. In the following section Colaizzi's (1978: 59-61) seven-step process of phenomenological data analysis as applied in this study is presented and discussed.

**Step 1: "*Read all of the subject's descriptions..... to acquire a feeling for them*" (Colaizzi 1978: 59)**

I read each transcription while simultaneously listening to the recorded interviews several times, to check for an accurate record of the participant's words. I then read all transcriptions again carefully a number of times to familiarize myself with the words of the participants in order to develop and gain a holistic sense (Holloway 2008: 182) of words. At this stage, Colaizzi (1978)

suggests acquiring a feeling for and making sense of the whole content of the data. During this stage any thoughts, feelings, and ideas that arose in my mind due to my emergency care experience was added to the reflective diary to assist with the bracketing and reflective process (Saunders 2003).

### **Step 2: “*Extract significant statements*”**

In this stage, I read the hard copy of each transcription again and statements, sentences or phrases that directly relate to dignity, older patients, and care practices were highlighted with a highlighter pen first and then highlighted on the electronic copy of the transcription in the Word document. This, according to Hycner (1985), is a very rigorous process of going over every word, phrase, sentence and paragraph. Colaizzi (1978: 59) suggests that you should extract significant statements or phrases from the transcriptions that directly pertain to the investigated phenomenon. This was a critical phase of the data analysis as it is here that the words seen to elucidate the researched phenomenon of dignity were extracted. Each transcription was a reflection of an ED nurse's description of experience. In that description were words or sentences which illuminated dignity and care practices that were important for dignity in the ED. Once the statements were highlighted electronically, each highlighted statement was cut from the transcription and pasted on to a separate sheet electronically, retaining the transcript number and line (Saunders 2003). As discussed previously, I did not specifically utilize any data analysis software other than the Word document on the computer. Indeed, Priest (2010) agrees that this process can be facilitated using the 'highlight' function available within popular word processing programs on the computer. Manually reading and highlighting, copying and pasting significant statements continued my immersion in the data (Saunders 2003).

Once all the significant statements were identified and extracted, I felt it was essential to leave them alone for a few days, avoiding as far as possible thinking about them (Whiting 2001). This I felt achieved a freshness in my

approach and returning to the statements later I was able to re-read the significant statements with 'openness' to the data, and to identify early themes that were emerging in the data (Saunders 2003). In addition, this also facilitated the process of phenomenological reduction (Whiting 2001), which is a key requirement in descriptive phenomenology research. An example of the highlighted and pasted statements are shown in the table 3.1

**Table 3.1 Example of identified and extracted statements**

Transcript & line no	Highlighted significant statements	Cut and pasted statements
Transcript 2 Lines 44-48	it's just things like <u>that they are not just a person in a bed</u> they have got they've got needs they have got erm... <u>they have got to have respect</u> and you know just that we are medically trained <u>it doesn't mean</u>	they are just not a person in bed they have got to have respect
Transcript 5 Lines 25-28	<u>they haven't got the knowledge to say yes or no I don't want this</u> or I didn't have this thing like that I mean some people  dignity for me would mean for a patient just for their basic rights that <u>they can be kept clean erm... for them to have food and drink and to be kept erm... covered up and not exposed to have their wishes met so if they ask for male staff only that that is met</u> erm...	it doesn't mean they (older people) haven't got the knowledge to say yes or no I don't want this  that they (older people) can be kept clean for them to have food and drink to be kept them covered up and not exposed have their wishes met so that if they ask for a male staff only that is met

### Step 3: “Formulating meanings”

In this stage, Colaizzi (1978: 59) suggests the researcher formulate meaning for each of the significant statements extracted from the transcriptions. He further emphasizes that the researcher must be involved with what he calls creative insight. This means that the researcher must leap from what the participants say to what they mean (Colaizzi 1978: 59). In other words, the researcher addresses the significant statements to determine whether what the participant has said responds to and illuminates the research question (Hycner 1985). In order to move into questioning the significant statements, it was important for me to acknowledge my presuppositions so that participants’ descriptions and meanings were not influenced by my experiences and assumptions. As Whiting (2001), citing Giorgi (1975) suggests, as an experienced emergency care nurse, it was not possible for me to have no presuppositions. To avoid misinterpretations of the participants’ views (Whiting 2001; Ashworth & Hagan 1993) I formally “bracketed” my experiences and assumptions through my reflective journal as part of the phenomenological reduction (Whiting 2001) as explained earlier.

Once presuppositions were stated and put aside as far as possible, I carefully examined all statements relating to the phenomenon of dignity to establish a sense of its meaning. To achieve this, the fundamental questions I asked myself here were: “*What does dignity means to ED nurses?*” Or “*What are ED nurses’ perceptions of dignity?*” and “*What does this tells me about dignity in the ED?*” (Saunders 2003). Formulated meanings were developed from each significant statement as illustrated in Table 3.2. Consequently, similar meanings were frequently formed from different participant statements.

**Table 3.2 Process of creating formulated meanings from significant statements**

Transcription & line number	Significant statements	Formulated meanings

Transcription 2, line 44-46	They are just not a person in bed It doesn't mean they (older people) haven't got the knowledge to say yes or no I don't want this	Older people are individuals Older people must be given choice and control
Interview 3, lines 227-229	They (older people) must be kept clean They must be kept covered up and not exposed Have their wishes met so that if they ask for a male staff only that is met.	Providing basic nursing care to the older person Providing privacy of the body Giving choice and control to the older person Dignity is difficult to maintain in some areas of ED.
Interview 3, lines 233-234	I just find it quite stressful in the department sometimes when you are in an area when you are trying to juggle a lot of balls keeping a lot of balls in the air just trying to maintain the privacy and dignity I find it quite difficult Well dignity is making sure your patients are clean and dry and making sure that they are fed and watered	It is stressful to maintain dignity when you are busy Dignity means providing basic nursing care and meeting nutritional needs.

#### **4. “Organize the aggregate formulated meanings into clusters of themes”**

Once the formulated meanings were created for all of the significant statements, arrangement of how to best cluster them into themes commenced. However, Colaizzi (1978) does not clearly explain how the formulated meaning should be clustered into themes. While previously the method was user-friendly, this step was unclear. I constructed my own method of creating clusters of themes from the formulated meanings of the significant statements. Colaizzi's (1978: 59) method is not definitive and can be adapted. Here I felt that it was necessary to

adapt the method to organize clusters of themes that were common to all the participants within the transcriptions (Colaizzi 1978: 59).

The method I adopted at this stage was to list the common and similar formulated meanings in columns, so that clusters of themes would begin to emerge that would reflect the research purpose. This involved reading each column and removing or adding, or changing aspects of the formulated meanings in each column to arrive at structural essence of the phenomenon (dignity). Removing, changing, adding or altering the meanings in each column is a method Husserl calls free imaginative variation and is important in determining which meanings are essential for the essence of the phenomenon being studied (Savin-Baden & Major 2014: 216; Kleiman 2004). I continued until common themes of dignity were generated. Nevertheless, this process did have its drawbacks, for example in some columns there would be similar meanings and themes emerging were alike. When this occurred, the two emerging themes were incorporated as one theme because they both had the essential feature of dignity. Finally the clustered themes were collapsed into prominent themes to illuminate the phenomenon of dignity as experienced and described by the participants. Table 3.3 illustrates this process

**Table 3.3 Illustration of how the themes emerged from the formulated meanings.**

1	2	3	4
Maintaining patient's self-respect is an attribute of dignity.	Older people should not be exposed during care delivery.	Older people must be respected as individuals.	Treating them with dignity, as individuals.
Respect older person's cultural beliefs are important in	Privacy of the body must be maintained at all times- must be covered up.	They are individuals and come with history.	Treat older people as you would want to be treated yourself or your family.
		They are a person and should be	



<p>marinating dignity.</p> <p>Respecting older people and gaining their respect.</p> <p>Speaking to them in a respectful manner.</p> <p><b>Emerging theme: Respect</b></p>	<p>Dignity is maintained by ensuring that they are covered up when changing/undressing.</p> <p><b>Emerging theme: Maintaining privacy</b></p>	<p>treated as human beings and not just a list or a diagnosis.</p> <p><b>Emerging theme: Treating the older person as an individual</b></p>	<p><b>Emerging theme: Treating the older person as individual</b></p> <p>(Incorporated with column 3 due to similar meanings)</p>
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At this stage, as Colaizzi (1978: 59) recommends, clusters of themes that emerged were rechecked with the recorded interviews and transcription to validate them. No discrepancies were noted amongst the various clusters of themes and the original transcriptions (Polit & Beck 2010:474). The emerging themes provided an insight into the meaning of dignity for the ten participants of the study (Whiting 2001).

### **Steps 5 and 6: “*Exhaustive description and fundamental structure of the phenomenon*”**

In the last two stages of the analysis, Colaizzi (1978: 61) suggests that the resulting idea should be integrated in to an exhaustive description of the phenomenon under study. An exhaustive description was written as a narrative account of emergency care nurses’ experiences of dignity in the ED context. It contained all the dimensions of the lived experience of dignity from the personal and professional perspectives of the participants interviewed (Saunders 2003). This was achieved by incorporating the emergent themes, theme clusters and formulated meanings into the description to create its overall structure, and ensure that it contained all of the elements of experience (Saunders 2003). The overall essential structure of dignity was collapsed into two main themes: Enabling respect for a person’s autonomy and compromise of dignity in the ED context. (See appendix G –Mind Maps).

**Step 7: “Returning to each subject and asking the subjects about the findings thus far”**

Colaizzi (1978: 61) recommends that the final validation stage of data analysis should involve returning the research findings to the participants to elicit views on the essential structures of the phenomenon to ensure that it presents their experience (Saunders 2003). Unfortunately, I was unable to make contact with two participants as they had left the area. The findings were returned to the other eight participants. Two participants returned views in writing while the others responded to me verbally to tell me that the findings entirely reflected their feelings and experiences. The two written views were as follows:

*‘Accurate findings, very difficult environment to work and enhance dignity in and this shows the true sentiment of ED nursing in current times’*

*‘The findings are true reflection of how difficult it is to work in the environment that we do. Nurses want to and strive to do the best for their patients in often challenging situation’.*

This is a recognized method of ensuring trustworthiness of data analysis. When findings are recognized to be true by the participants, the trustworthiness of the data is further established (Streubert & Carpenter 2011: 93). Another method of validation used in data analysis includes peer review. Data analysis was supervised by one of my supervisors to ensure the process was clear and auditable at every step of the process.

**Strategies Used to Enhance the Quality of the Study**

Research findings should be as trustworthy as possible and every research study must be evaluated in relation to procedures used to generate the findings (Graneheim & Lundman 2003). While there are a number of perspectives and methods of assessing the rigour of qualitative research the most common established criteria of credibility, transferability, dependability and confirmability by Lincoln and Guba (1985) are used to determine the quality of this study.

The credibility of the study refers to the value and believability of the findings (Polit & Beck 2014: 323). In general this means how believable, and accurate the reported findings are and how credible is the research process. Credibility of a qualitative study can be determined by assessing the strategies adopted to demonstrate credibility. Some of the strategies associated to achieve credibility include, appropriate and relevant sampling decisions, data triangulation, member checking and peer review and reflexivity (Anney 2014).

Purposive sampling was used to select ED nurses who had the knowledge and experiences of caring for older people which allowed the essential structure of dignity to be revealed and described. Inclusion and exclusion criteria in selecting information-rich participants for the study ensured that data triangulation could be incorporated so that a full and accurate understanding and perceptions of dignity could be obtained (Pitney 2004) from a variety of aspects. Data triangulation takes many forms but involves collecting data from multiple and varying sources (Pitney 2004). In this study choosing participants with various years of experience and holding different ED job roles increased the possibility of providing an understanding of ED nurses' perceptions of older people's dignity in the emergency care context from a variety of perspectives (Graneheim & Lundman 2013).

Member checking involves providing the study participants with the transcriptions of their interview or interpretations of the results so that they can verify their accuracy (Pitney 2004). This is another strategy for enhancing the credibility of the study (Anney 2013). In this study member checking was conducted following data analysis. A summary of the results was sent to participant with a request for feedback either via e-mail or in person. Two participants sent written views and others conveyed in person. All participants agreed that the findings were accurate and represented their perceptions of dignity in the ED context.

Peer reviewing entails having an external qualified researcher examine the research processes and data interpretations (Pitney 2004). As a novice researcher undertaking this study as part of the professional doctorate degree, I was supported by three very experienced academic members of staff. One member of staff was especially responsible for peer reviewing the process of data analysis so that data coding and thematic structures were logical and appropriate (Houghton et al 2013). How this was carried out has already been discussed in chapter three. The process of peer review and feedback helped in ensuring that the quality of the study, methods of data collection and analysis were appropriate and systematic (Pitney 2004), thus further contributing to the credibility of the study.

Reflexivity was maintained throughout the study and is associated with establishing dependability and conformability of the study. Dependability and conformability are closely linked and refers to the credibility and neutrality of the study and its findings (Streubert & Carpenter 2011: 28). More importantly in this study I was the research instrument and the reflective journal enabled me to take into account my experiences, feelings, thoughts, and biases concerning the overall research process (Krefting 1991; Houghton et al 2013).

Transferability refers essentially to the probability that the study findings have meanings to others in similar settings or groups (Streubert & Carpenter 2011: 49). In qualitative study, it is the readers of the research study who can decide whether or not the findings are transferable to their own setting or groups (Graneheim & Lundman 2013). In providing a detailed description of the study site, sample selection strategy, characteristics of the participants, data collection methods and process of analysis (Graneheim & Lundman 2013) readers of this research study can determine if the findings are applicable to them and their clinical setting. Moreover, rich and vivid presentations of the findings using direct quotes from the participant experiences to illustrate the

emerging themes further enhances the reader's decision whether or not the findings are transferable (Houghton et al 2013; Graneheim & Lundman 2013).

Even though a number of strategies were adopted in enhancing the quality of this study, Patton (1999) further advises the qualities and perspectives the researcher brings to the field, must also be included. This study was conducted in the ED where the researcher works and the issues surrounding conducting 'insider research' were also pertinent to the study. The researcher's experiences, training, preparation and perspectives that impacted the study have already been discussed. Streubert and Carpenter (2011: 29) believe the criteria of credibility, dependability, conformability and transferability for judging the quality of qualitative research are extremely important. While I have used a variety of strategies associated with qualitative research, in particular with phenomenological research, it is for readers of this research study to decide if it is of interest to them and their clinical practice.

## **Summary**

This chapter has presented the methodology and the methods chosen and utilized to conduct the study. To enable understanding of ED nurses' experiences of older people's dignity in the emergency care context, a descriptive phenomenological approach was used to underpin and guide the study. In-depth interviews as a method of data collection and Colaizzi's (1978) approach to data analysis were used.

## Chapter 4: Findings and Discussion

### Introduction

Phenomenological analysis of the data gathered during the course of this study identified two prominent interrelated themes and eight subthemes:

1. Enabling respect for a person's autonomy.  
(Subthemes: respecting the older person as an individual, maintaining privacy of the body, providing good nursing care and giving information and choice).
2. Compromise of dignity in the ED context.  
(Subthemes: not having the time to provide care, staff attitudes and perceptions of older people, patients with dementia and environmental constraints).

The two prominent themes provide distinctive understanding and perceptions of older people's dignity as experienced and described by participants working in the ED context. The findings and discussion are integrated and each prominent theme and subthemes will be presented and discussed as an exhaustive description in alignment with Colaizzi's (1978) phenomenological method, using quotations from the participants' narratives to illustrate significant points. Each exhaustive description will then be discussed in the context to current literature. First, a profile of the participants who contributed to this study is presented.

### Participant Profile

Ten participants were recruited. All were qualified nurses and at the time of the interviews were working in the ED in which the study was located. Participants had a wide range of emergency nursing experience, ranging from junior staff nurse to clinical nurse manager. All participants were employed according to Agenda for Change pay scale bands. Participant experience and their role within the ED is summarised in Table 4.1.

**Table 4.1 Participant Profile**

<b>Participant number</b>	<b>Current position</b>	<b>Years of experience in emergency care</b>
1	Band 6 junior sister	30 years
2	Band 6 junior sister	10 years
3	Band 5 staff nurse	10 years
4	Band 6 junior sister	12 years
5	Band 5 staff nurse	6 years
6	Band 5 staff nurse	2 years
7	Band 7 clinical nurse manager	20 years
8	Band 5 staff nurse	2 years
9	Band 7 senior sister	18 years
10	Band 5 staff nurse	15 years

**Theme 1: Enabling Respect for a Person's Autonomy**

All participants were asked to describe their experiences and perceptions of dignity as experienced by them within the ED. Participants described dignity as an important component of their nursing care. Each participant's account of dignity was distinctive and embedded within their *life-world* of the ED. The ED was described as a unique care environment encompassing of a number of different areas within the care setting. Patients are cared for in each area according to the severity of their presenting condition and care needs.

Participants' accounts of the concept of dignity were drawn from their everyday experiences of the care they provide to older people in all areas of the ED.

Respect for the older person's autonomy emerged as a dynamic intrinsic concept of dignity. All participants described dignity as actions inherent to autonomy. Dignity was conceptualised as seeing and treating the older person as an individual human being. Participants further described respecting the older person, maintaining privacy, and giving information and choice as attributes of older person's dignity.

### Respecting the older person as an individual

This subtheme was identified as the participant's recognition of the older person's sense of worth and individuality. Participants described the importance of recognising older people as individuals and treating them in the context of respect. Sudden attendance at ED and the impact this could have on the vulnerable older adult was also recognised by the participants as an aspect of dignity and respect. In relation to nursing care, participants believed that older people's individual needs, wishes and culture should be respected:

*'Remembering, that older people are individuals, and not just conditions that have come through the ED doors. Treating them as you want to be treated or you would want your parents to be treated. I think that remembering that they are human beings.....'* (Nurse 6).

And

*'You should actually respect the older patients and listen to them. Listening to what they say and doing as they ask you to do is important '* (Nurse 6)

And

*'We have to meet their cultural needs, as some female patients from certain cultures don't want male patients to undress them or carry out procedures such as ECG's.....yes respecting the patients, their beliefs'* (Nurse 2).

In this context, participants position respect as paying attention to and valuing the individual needs of older patients. Participants regarded and viewed dignity in terms of respect. Respecting and treating the older person with due regard to their personhood; that is, the nature of the person, their individuality and feelings. The word respect was used repeatedly in the narratives to convey perceptions of dignity.

The term respect in relation to dignity is not a new concept. During the last decade in several government strategies, guidelines and empirical evidence, respect is the most frequently used word to describe dignity. Respect for the



individual person is not only integral to the concept of dignity, but is also an ethical and a moral principle for nursing. Respect within the professional code of standards for nurses acknowledges autonomy and self-determination (NMC 2015). More precisely, as a nursing ethic, respect permeates all aspects of nursing practice (Brown 1993). Ethical behaviour of the nurse is the day-by-day expression of one's commitment to other persons and the ways in which human beings relate to one another in their daily interactions (Levine 1977). Notably, all participants knew and understood that respect for the person is embedded in their professional code of standards of practice and behaviour and thus perceived that they must act in line with their professional and moral principles. The findings observed in this theme mirror those of previous studies exploring older people and health care workers' views and perceptions of dignity in other care settings.

Hall et al (2014) explored the views of care home staff, community nurses, older residents and their families on maintaining dignity. They conducted semi-structured interviews with thirty-three care home managers, twenty-nine care assistants; eighteen care home nurses, ten community nurses, sixteen older residents and fifteen members of resident's families. All saw dignity in terms of respect. Treating the older person with respect was cited by all participants as perceptions of dignity. The authors described how all participants used the term 'respect' in their narratives to illustrate their understanding of dignity: "*dignity is respect*" or "*you should have respect for your elders*" were sentences or words that were repeatedly used. Even though that study was not conducted in an acute environment, the participants' views' and perceptions of dignity are very similar to the current study. The findings of the current study and those of Hall et al (2014) are consistent with earlier studies. Bayer et al (2005) explored older adults' views of dignity in 6 European countries and found similar views and perceptions of dignity. In all the countries, older people emphasised that fundamental to experiencing dignity, was being shown respect from others and having respect for oneself. Despite the wide range of backgrounds of the older

adult participants in Bayer et al (2005) study there was substantial agreement about the meaning and experience of human dignity in their lives. The participants in the current study, who even though, work and provide care in an extremely complex environment, share the same views and perceptions of dignity as those of older people themselves and other health care professionals in non-acute care settings.

Participants in the current study further recognised the vulnerability of older people. They discussed the fact that when older patients attend ED they can be scared and vulnerable. Attendance at ED commonly occurs suddenly, whereby patients have had no opportunity to prepare physically, socially or mentally for their visit to ED. The participants were conscious that when this happens, patients experience pain, fear, stress and anxiety.

*'I think patients feel very vulnerable when they come into hospital any way.....so maintaining their dignity would not increase that vulnerability'*  
(Nurse 4).

Vulnerability is an essential part of the human condition. It is closely connected to our lived experiences as human beings (Gastmans 2013). Harm may come from many sources and we are never entirely free from the possibility of being harmed (Goodin 1985.) However, in contrast to the ordinary human vulnerability we all share, older people are regarded as more susceptible to vulnerability. Due to their age, chronic illness, and often poor physical health, older people are more vulnerable to harm (Rogers 1997). Vulnerability is not only associated with physiological harm, but also with psychological impacts such as fear, helplessness and isolation (Rogers 1997). Vulnerability can be affected by personal factors as well as environmental factors (Rogers 1997). In exploring older people's perceptions of vulnerability, Abley, Bond and Robinson (2011) found that in general older people did not see themselves as vulnerable. For them vulnerability was related to being in a particular situation, when 'at the mercy' of one or more other people such as being in hospital and at the mercy of a health care professional (Abely, Bond and Robinson 2011). Sudden effects

of acute illness and admission to ED mean that older people cannot meet their own physical or psychological care needs and must rely on nursing care. Participants in this study recognised this and discussed that in these situations patients may be afraid regarding their medical condition or the unknown consequences of the illness (Baillie 2005). Being a patient and the experience of a sudden unknown illness is known to cause the individual to feel a state of powerlessness (Coventry 2006). In these circumstances, the participants believed that time should be taken to reassure patients by listening to their concerns and fears during care. Spending time with the patients and understanding their needs was seen as showing respect for the individual patient:

*'Making sure that their dignity is maintained by talking to them in a normal voice even if they are deaf, don't be shouting at them.....making sure they have their hearing aid or glasses and just being aware of what they are like independently' (Nurse 7).*

While, this was rhetoric that several participants advocated, another participant highlighted that the reality of what actually takes place, does not always measure up to this ideal:

*'Sometimes nurses don't listen to patients', they just go into the patient's cubicle and do the task rather than remembering that he or she is a person. The patients could be scared or vulnerable because they don't know us. Just taking a bit of time to spend with them, so that they are not frightened is showing respect' (Nurse 6).*

Communicating sensitively and appropriately is at the heart of dignified care. Evidence relating to older people's perceptions of dignity suggests that the right kind of communication can engender a feeling of respect, whereas poor communication can make the person who is receiving care feel unworthy and uncared for, even if the physical aspects of care are in place (Levenson 2007). Why some ED nurses do not initiate sensitive communication, could be due to several factors; for example, the complexities of the emergency care environment.

In the UK, EDs are regarded as complex and dynamic care environments, where care is focused on providing initial treatments to patients with a broad spectrum of illness and injuries (Nolan 2009). Over 20 million people use ED services each year (Baker 2015) and it is noted that nursing care is becoming utilitarian and nursing interventions are carried out according to fixed schedules (Nystrom et al 2003). The organisation of nursing care in the ED is characterised by a high degree of division of labour (Nystrom et al 2003). Often one trained nurse, supported by an untrained care worker, is responsible for eight patients in a specific area. Nursing staff are allocated to specific areas within the department, such as triage, resuscitation room, and major's. Time pressures due to the introduction of the four-hour target for ED, whereby patients should be assessed, treated and either admitted or discharged within four hours make consistent demands on the nurses.

It has been reported that ED nurses are confronted with more difficult work conditions than general hospital nurses, and work under higher time pressure (Adriaenssens et al (2011). While a speedy journey through the ED is generally regarded as in patients' best interests, nursing staff have a tight time frame during which they must help patients feel they have been treated as individuals and cared for as human beings (Baillie 2011: 161). What little time participants have is focused on the physical task, with little or no attention being paid to the more holistic aspects of care, such as having the time to talk and listen to the patients. While some participants were conscious and aware of the fact that anxiety and fear do exist and how to address it, the influence of the ED environment may leave them with insufficient time to communicate effectively. Previous studies have found that despite ED nurses recognising older patients' vulnerability and the importance of having an insight into their fears and concerns, not having enough time to spend with the patients is seen as a barrier to achieving this (Kihlgren et al 2005; Byrne & Heyman 1997). Nurses have a professional duty to protect the vulnerability of the older people in their care. However, even though participants recognised this vulnerability

and the negative effects of their actions such as poor communication have on older patients, due to lack of time 'completing a physical care task' is seen as a priority over sensitive communication. This results in the nurse-patient relationship being devalued by some participants in favour of a task-centred approach to patient care (McCabe 2004). As Rogers (1997) concludes, a nurse may be able to recognise the holistic needs of the patient, however, due to an environment designed to meet the acute physical problems, this can have an impact in how the holistic care is delivered and this is evident from the participants' stories.

#### Maintaining privacy of the body

A number of dignity promoting actions and views were described by the participants in the context of respect. This included respect for privacy. Privacy was described by all participants as an attribute of older patients' dignity. In the ED, as in most care settings, the process of physical examination and diagnosis necessitates some bodily exposure of the patient. Participants rated privacy in relation to not exposing older patients' bodies unnecessarily during these events. Maintaining privacy of the body as much as possible in care delivery and during physical examination was seen as an important concept of dignity. The following narratives illustrate this point:

*'If they are being examined or being changed they should have the curtains and the door shut'. (Nurse 5)*

*'Dignity to me basically means doing everything that you possibly can for the patient, maintaining their privacy, dignity and keeping them covered and not left to be exposed' (Nurse 9).*

The fundamental importance of privacy is recognised through its protection in Article 8 of the European Convention of Human Rights (Levenson 2008). It is also rooted within the nurses' code of professional standards (NMC 2015) and a number of professional and government policies and strategies further foster the importance of respect for privacy. The need for privacy is a basic human

right and is considered as one of the key concepts in nursing (Back & Wikblad 1998). Privacy and dignity are important human needs, and every patient, especially vulnerable older patients, has a right to experience them (Whitehead & Wheeler 2008). The integrity of privacy was reflected in the participants' narratives. Participants exemplified acts such as closing doors and drawing curtains, during intimate care as ways of ensuring patients' privacy and dignity:

*'I know it sounds stupid and simple, but closing doors, curtains and keeping patients covered when you do something personal is really important'* (Nurse 6).

*'Dignity is something we promote.....it's about ensuring privacy'*  
(Nurse 8).

A central principle of nursing as a practice discipline is that all nurses in all care settings work in close and continuous association with older patients who are vulnerable. Vulnerable older adults are often partially or totally dependent on the nurse for maintaining their care needs and preservation of dignity.

Therefore, within this theme, participants recognised that the responsibility of protecting older patients' privacy rests with them. The active effort of drawing curtains and closing doors is done to preserve privacy and reinstate dignity.

This subtheme, adds to the growing body of literature on what constitutes dignity in health care. The respect for patients' privacy has appeared as a thread in a number of studies exploring older patients' and health care professionals' experiences of dignity. Walsh and Kowanko's (2002) study of patients' and nurses' perceptions of dignity in a teaching hospital reported similar findings to the current study. Data were collected from five patients' and four nurses' using in-depth interviews. Nurse participants were asked to describe their experiences where patient dignity had been maintained or compromised. Likewise the patient participants were asked to describe situations during their hospitalisation in which they felt their own dignity had been maintained or compromised. All participants described the notion of dignity linked to privacy and respect. Nurses' spoke of the importance of

screening the bed area while performing care procedures. Patients' described similar views and perceptions and felt that respect for privacy, especially in relation to exposure of the body to the gaze of others, was central in maintaining and compromising of dignity (Walsh & Kowanko 2002). In a large study, Matiti & Trorey (2008) explored hospitalised older patients' views regarding factors that contributed to the maintenance of their dignity and conveyed similar findings. One hundred and eight (108) interviews were conducted with older patients over an 18-month period. The authors found that older participants regarded privacy as one of the most important factors of dignity. In addition, participants reported that nurses made every effort to respect their privacy by ensuring that curtains were drawn around them during care procedures. These findings show a strikingly similarity to the subtheme which emerged from the current study.

#### Providing Good Nursing Care

In describing their perceptions and views of dignity, several participants simply said that good nursing care of older people should be a nursing priority and a way of enhancing dignity. They believed that this was the main role of nursing and it was the older person's human right to receive good nursing care:

*'It's basic nursing care that should be given to patients and it should be twenty four hour care. As nurses our main priority is nursing care, it is why we came into nursing, to care for patients'. (Nurse 7)*

The nursing theorist, Madeleine Leininger describes care as the essence of nursing and its distinct, dominant and unifying feature. She believes caring involves actions to assist, support, or facilitate another individual or group with the evident or anticipated needs to ameliorate or improve a human condition or life ways (Leininger 1988). While this is a generic definition of nursing care, the participants' narratives present their perceptions and understanding of nursing care associated with older people as shaped by their experiences within the ED context. Providing nursing care that meets the personal care needs of older people in a way that promotes their dignity was recognised by a number of

participants. There was general agreement among all participants that good basic nursing care was related to maintaining dignity. All participants used similar words, sentences and phrases to express the elements of care. The following participant statement provides an insight into what constitutes good nursing care:

*'Basic nursing care means making sure patient's care needs are met. It's making sure that they can go to the toilet when they need to go. It's about making sure they are clean and dry if they are not able to use the toilet. It's about making sure they are fed, have got privacy and dignity'.*  
(Nurse 7)

In the *Guidance for the care of older people*, the NMC (2009) stipulates that basic nursing care for older people is fundamental and should consist of meeting their nutritional, hygiene and continence, needs. Furthermore it indicates that: *"What nurses describe as basic care is in fact fundamental or essential care of an older person and is the foundation of the healing and therapeutic process"* (NMC 2009:9). Maintaining personal hygiene is directly related to individual self-esteem, sense of wellbeing (Curtis & Wiseman 2008) and dignity. Due to their illness, age- related changes that can impact on body systems or even personal circumstances such as living alone, older people attending EDs can be in various state of personal hygiene. More significantly, they can also remain in the ED for an extended period of time (Curtis & Wiseman 2008). Participants' narratives identify that even in a rapidly changing traditional ED model of rapid assessment and treatment focusing on diseases and conditions, basic nursing care is vital for the health, comfort and preserving the dignity of older patients (Baumbusch & Shaw 2011; Curtis & Wiseman 2008).

A large number of older people develop urinary incontinence in later life. The impact of incontinence is not only a sensitive issue but is also associated with embarrassment, anxiety and psychological effects (Miller 2009: 397; Healthcare Commission 2007). Providing timely support and access to the toilet is



important in reducing episodes of urinary incontinence (Al-Hayek & Abrams 2005). From their descriptions of what constitutes basic nursing care it is evident the participants recognise this, and also understand that older patients often depend on them for assistance with elimination and they as caregivers must ensure that these needs are met (Miller 2009: 397) timely and sensitively.

The Healthcare Commission (2007) emphasises that nutrition is an essential aspect of basic nursing care and ensuring that older patients are provided with appropriate food and drink is a dignity issue. Nutrition is also vital for health and wellbeing and frail older people are regarded as at higher risk of developing malnutrition because of their dependence on others to provide food and drink, especially when in hospital (Copeman 2011:174). However, a number of reports such as the Francis report (2013) and the Health Service Ombudsman (2011) have indicated that older patients are not always given appropriate food and drink during their stay in hospital. The participants' narratives in this study regard nutrition as one of the most important elements of basic nursing care of the older patient. These findings are similar to the expectations of older patients and their families of nursing care in the ED.

A recent qualitative study exploring the experiences of relatives who accompanied an older patient to ED, Morphet et al (2015) found that relatives wanted and expected the ED nurses to provide basic nursing care to their family member. In this Australian study, data was collected through semi-structured interviews with twenty-four relatives of older people who were admitted to ED in the previous three years. Comfort, hygiene and hydration were the basic nursing care needs listed by the relatives as important and a priority in the care of the older patient in the ED. Help the Aged (2008) in describing what constitutes dignity and dignified care of older people, identified a number of domains as a framework for understanding dignity. Privacy, personal care, eating and nutrition and personal hygiene are some of the domains identified and are similar to those, identified by the NMC (2009) in their document

*Guidance for the care of older people* and by the participants in this current study.

Basic nursing care can mean different things to nursing staff groups, patients or relatives and can be influenced by the environment, and context (Reid 2014). It is evident that participants in this study understand what basic nursing care of an older person means to them in the ED context and is further viewed as enhancing dignity.

### Giving Information and Choice

This subtheme was further innate to the concept of autonomy. Several participants spoke of giving older people information regarding their care and the opportunity to make decisions and choices. This was further seen as an essential attribute of dignity. Participants agreed that older people should be given choice in all aspects of their care, including undressing in preparation for medical examination:

*'I always ask the patient if they would like to remain in their own clothes or go into a gown. A lot of patients don't want to be in gowns but everyone is so focused on stripping patients and putting them into gowns, they don't give them a choice' (Nurse 8)*

In almost all areas of the ED, especially in major's all patients go through a similar routine. Once initial assessment is carried out by the admitting nurse, patients are then prepared for a medical examination. While it is not a written policy that all patients must be changed into hospital gowns for medical examination, it is the norm in ED for patients to do so. Nevertheless, similar practice is also common in other care settings such as outpatients, medical and surgical wards (Baillie 2009; Baillie & Gallagher 2011). This practice however is not challenged by nurses who are directly involved with caring for older patients or by nurse managers even though empirical evidence suggests that putting older patients routinely into hospital gowns can impact on dignity. Older patients themselves have reported that they feel passive and undignified in hospital gowns (Woogara 2005; Hall & Hoy 2012). Professional guidelines such as: *The*

*Guidance for the care of older people* suggests that nurses have an important role to play in ensuring that their care promotes choice and independence (NMC 2009). However, the reality is that while some nurses recognise this, it is not actively promoted by everyone. Hospital gowns were never designed to be used for preparing patients for physical examinations they were designed for use in operating theatres (Woogara 2005). In ED, nurses have become accustomed to accepting this practice as 'norm' (Baillie 2009) and a task, when in reality this type of practice should be challenged. This routine practice of unnecessarily undressing and putting older patients into hospital gowns imply that some nurses are providing care based on either their own or ED's priorities rather than the patient's priorities (Milton 2008). Nevertheless, as highlighted by the participant's narrative, giving an older patient the opportunity to choose what they would prefer to do, the ED nurse can do a good deal more to uphold a patient's dignity (Baillie 2011: 168).

Giving older patients even a simple choice of remaining in their clothes shows participants respect patients' autonomy. Autonomy is viewed as an individual's ability to make self-determined choices and involves independence, the capacity to reason and decision making ability (Scott et al 2003). Within healthcare context, a key reason for concern with autonomy is to ensure that patients are respected as human beings, and that their rights as human beings are promoted and protected (Scott et al 2003). Several participants further realise the importance of this. The following statement demonstrates how a participant upholds a patient's autonomy by giving her information, choice and independence:

*'An elderly 86 year old lady came in she was placed into a cubicle. She was very short of breath, but she needed to be undressed for examination.....I introduced myself and explained that she needed to get changed into a gown. I asked would she mind getting undressed and would she like some assistance as she was very short of breath. She said she would like some help.'*

*Sometimes we need to take our time and explain to people and assist them.....' (Nurse 10)*

These findings make further contribution to the existing literature relating to the dignity of older people in health care. Older patients in previous studies have themselves have expressed the importance of having choice and involvement in care. In Bayer et al's (2005) study, older participants discussing their perceptions of dignity expressed that they wanted to retain control of decisions about their care and placed great value on being fully informed. Matiti and Trorey (2008) further confirm these findings and found that older participants in their study expressed the desire to have the opportunity to make choices about their care. This made older participants feel that they were more involved, or that they had more control over what was happening to them. This study further reported that participants felt that nurses did their upmost best to encourage their independence through explanation and choice (Matiti & Trorey 2008). These studies (Matiti & Trorey 2008; Bayer et al 2005) report how older people value information, choice and control as important constituents of dignity. While the findings of the current study make several contributions to the existing literature, a small number of participants also expressed concern at how some nurses assumed that older people were incapable of making decisions and choices and did not take the time or effort to explain what they were doing, thus the respect for autonomy being lost. A participant expresses the following viewpoint:

*'.....just because we are medically trained it doesn't mean that older people haven't got the knowledge.....you need to sit down and explain to them what you are doing, give the reasons and let them make an informed decision'. (Nurse 2)*

Other participants further mentioned how some nurses often ignored older patients, did not involve them in conversations, let alone giving them choice and control regarding their care:

*'I have noticed a lot of nurses who talk over the patient about other things as if the patient's not there and they will just chatter about what they*

*were doing the night before or saw on telly and not talking to the patient. I always think you can do some chatting but let's involve the patient because I think that they already feel as though they are insignificant or they are just one of a list of patients under your care.....' (Nurse 4)*

Any type of communication is an essential component of the nurse-patient relationship. Communication enables the nurse and patient to share information, thoughts, and feelings (Hood 2010: 81). Older patients themselves have stressed that when nursing staff ignore them and 'talk over their heads' it made them feel disregarded, excluded and violated their dignity (Matiti & Trorey 2008; Webster & Bryan 2009). Being totally ignored as a person is a form of inhumanity or uncaring attitude (Wiman & Wikblad 2008). The meaning behind why nurses behave in this manner could be related to a number of reasons for example, nurses' vulnerability, stress and burnout. Stress and burnout among nurses, especially in the ED, have long been recognised to have a huge physically and psychological impact on nurses.

While the vulnerability of the older person is discussed in health care, there is little recognition that nurses and other healthcare practitioners can also experience feeling of vulnerability (Heaslip & Board 2012). The impact of experiencing staff vulnerability has physiological and psychological health implications. Heaslip & Board (2012) argue that an awareness of staff vulnerability is integral to having workforce that is fit to practice. Pope (2012) believes that to provide holistic, individualised patient care, requires a caring environment, which nurtures and understands its members. Working in an unpredictable environment, where overcrowding, organisational pressures and institutional and government policies (Wolf et al 2016) is a daily norm can expose ED nurses to several risk factors. Perhaps the daily exposure to such events generates feelings of vulnerability amongst the nurses. To protect themselves from feelings of vulnerability, nurses focus on the more technological and specialised aspects of care and switch off their emotions to prevent themselves from being hurt (Heaslip & Board 2012). As a result, the

care delivered becomes task orientated, lacking in compassion and involvement, and nurses adopt negative attitudes towards patients, especially those who are older. As these attitudes are practiced they become the norm and are difficult to change once integrated into the environment culture (Pope 2012).

### **Summary**

In this first theme, participants' views and perceptions of dignity were extremely similar and entrenched within their life-world of the ED. Their experiences provided an insight into their understanding of older people's dignity. Dignity was conceptualised as actions innate to autonomy. To the participants dignity meant respecting and treating the older person as an individual human being. Activities such as maintaining an older person's privacy during care delivery and meeting patients basic nursing care needs such as nutrition and hygiene were viewed as important components of dignified nursing care. Equally, dignified care was also described as giving older patients information, choice and control regarding their care. Nevertheless, it was also evident that some care practices such as routinely undressing patients for physical examination were accepted as a 'norm' by some participants and this existing practice is not challenged.

### **Theme 2: Compromise of Dignity in the ED Context**

This was the second core theme to emerge from the participants' narratives of their experiences. This theme relates to participants perceptions of how older patients' dignity can be compromised within a very busy and complex emergency care environment. Four subthemes contributed to this theme - not having enough time to provide care, staff attitudes and perceptions of older people, environmental constraints and care of patients with dementia. Participants described difficult experiences and struggles influencing the provision of dignified care in the ED.

### Not having the time to provide dignified care due to work pressures

Participants spoke of the difficulties they encounter during busy times to maintain older people's dignity:

*'When we have lots of patients in the department, it has an impact on giving dignified care; it has an impact on the patient's journey through the hospital.....' (Nurse 2)*

In 2014/15 there were 22.4 million attendances at England's emergency departments. Total patient attendance has increased by 2.7 per cent compared to 2013/14 (Baker 2015). With the increasing number of attendances, nurses have to care for many more patients. It has already been identified that there are not enough nurses in EDs to provide quality care. Draft guidance issued by the National Institute for Health and Care Excellence (NICE) focuses on staffing levels and the number of nurses needed on a shift in ED to provide safe care (Ford & Lintern 2015). Recent evidence suggests that current staffing levels in ED and other acute care settings leaves many care tasks undone (Ball et al 2013). It is frequently claimed that nursing is vital to the safe, humane provision of health care and health services (Scott et al 2014). Nevertheless, nurses work in a health service where numbers matter and the measurable is influential (Norton et al 2015). In ED and other care environments, the focus is on maintaining the minimum nurse staffing needed to prevent harm, rather than the nurse staffing levels needed to deliver excellence and individualised patient-centred care that encompasses nursing values (Norton et al 2015). It is clear from the participants' narratives that they understand the core value of dignified nursing care. However, they also recognise the difficulties associated with delivering individualised care with the competing time pressures and poor staffing levels. This is so excellently expressed by the following participants:

*'It's terrible when we are short staffed.....you have dementia patients who are our priority but you've got no staff that can sit with them..... It's hard work on everybody else because you can't offer them the level of care with the amount of staff we have on sometimes....' (Nurse 9)*

And

*'You haven't got the time to spend explaining or sitting with your patient as you would like to.....I find it quite difficult to sit with your patient because you have got too many patients and usually one nurse and support worker to care eight or nine elderly patients. I find it quite stressful.....ultimately because of the environment and the pace that we work under it's very difficult to maintain dignity' (Nurse 3)*

The emergency department is a portal entry into care for a number of patients, including older people with dementia or mental health problems. The care of patients with dementia and dignity is discussed later in the chapter. Delivering high-quality, individualised psychiatric care is an increasing challenge for many ED nurses. Due to poor staffing levels, and the pressure of caring for a large number of patients, ED nurses regularly feel frustrated in their efforts to provide dignified care to older patients, including those with serious mental illness (Wright et al 2003). This is demonstrated in the following extract:

*'A lady came in.....and had mental health issues and needed to talk and was desperate to talk and I found myself backing out of the cubicle because I was in triage and needed to get back.....it's just the sort of department we work in you just can't sit down and spend time with the patients in the way that would help'. (Nurse 4)*

The participant further explains how her colleague who was assigned to look after this patient could not provide the care and support this patient required:

*'The lady felt she had been let down by the health system all along and she was getting to the end of her tether so it would have been nice to really sit down and give her some care but I had more people waiting to be triaged the nurse in the area was rushed off her feet as well because she was working on her own in that area on that day so she was really struggling to keep up'. (Nurse 4)*

In many ways, the above narratives reflect a basic tension between the nature of the emergency nursing work and the clinical needs of older patients including those with serious mental health problems. All patients with psychiatric health



problems typically need more time-intensive, psychosocial support in addition to traditional emergency care (Wright et al 2003). The care such patients receive is often heavily influenced by the staffing levels and the nurses' workload. As the above narratives demonstrate, ED nurses are torn between providing the care they believe these patients deserve and the actual care delivered. The participants' narratives suggest that they wish to be able to have the time and staff resources to prioritise the 'talk to patients' aspect of the care (Norton et al 2013).

Nystrom et al (2003) explored the experiences of nine nurses working in ED to gain an in-depth understanding of conditions underlying inadequate nurse-patient encounters in a Swedish emergency care unit. The study was carried out with a life-world hermeneutic approach using interviews. The authors described how nurses paid little or no attention to patients' psychosocial and/or existential needs in the ED. Attention was only focused on the physical care needs of the patients and care was carried out quickly and according to fixed schedules and concrete interventions, and there was no time left to discuss how to take better care of patients. The authors described how the ED nurse coordinator (manager) organised both medical tasks and caring interventions and nurses were expected to respond to these instructions. Participants highlighted how rules and schedules were seen as having greater importance than considerations about patients' individual care needs. The authors concluded that nursing care provided in the ED resembled a conveyor belt industry. The concept of care provided comprised only practical/physical interventions and this seemed more important to management than alleviation of suffering and deeper understanding of patients' individual care needs (Nystrom et al 2003). While Nystrom et al's (2003) study did not explore nurse participants' views and perceptions of dignity, the findings have some significance to the current study. The issues of excessive workload, unsupportive managers, meeting tight schedules and care that is constantly rushed are similar to the experiences of participants in this study.

When participants further described their experiences of older people's dignity in the ED, their stories focused on how the government's four-hour waiting time policy impacted on delivering dignified care. During the last decade, EDs have struggled to meet this target and the subject has been under great public, political and media scrutiny. Participants described how the impact of poor staffing levels and the added pressure of meeting the four-hour target means that patient care is often rushed, carried out quickly and compromises dignity:

*'Sometimes your patient may be wet and requires changing. Due to staffing levels or you being busy you have not got around to changing the wet patient. The patient gets moved to a ward before you have had the chance to go into the cubicle to make sure your patient is clean and dry. Last week a patient was moved to a ward who needed changing and the nurse in charge didn't ask me whether the patient was ready to go.....I try to make sure my patients are clean and dry but sometimes due to patient targets managers move patient to the wards...'*  
(Nurse 3)

And

*'It's because of targets.....your four hour targets in ED. Sometimes patients are moved quickly and it's not always possible to give them the time, the care...you feel rushed if you need to clean them up in a hurry. Patients are coming in thick and fast so we are having to move them into a bed in the hospital quickly as possible and sometimes you're in the middle of something and the porter will arrive because the patient needs to go so you have to finish what you are doing as quickly as you can....due to the targets we do the essential stuff, we do the medical care.....'* (Nurse 4)

Several participants reported that they were constantly under pressure from managers to move patients to the wards within the target time, even if patient care was incomplete, or the patient was being transferred to a ward in a wet bed. It was obvious from their narratives that some managers were only

concerned about meeting the four-hour target instead of quality nursing care that enhanced dignity.

*‘Some nurse managers tend to be more focused on the targets and wants to move patients out of ED fast.....I know targets are important but I will not and cannot send a patient to the ward if they are wet just because they are going to breach the target. I am sorry I think it takes me two minutes to change a bed and I am justified in making that decision.....the patient care comes first’. (Nurse 6)*

And

*‘There is a lot of pressure from management to move patients due to the four hour breach targets.....patients are moved from ED even if they have not had pain relief or if they want the toilet you quite often have to say to them to wait until you get to the ward.....’. (Nurse 8)*

And

*‘.....Very often patient dignity is denied because the patient is coming up to what we call the four hour breach time so the patient may be wet but we are being told by managers to move patients to the wards in wet beds.....’. (Nurse 7)*

Waiting times were the greatest cause of distress for patients attending ED, prior to the introduction of the four-hour policy. Patients experienced long delays for assessment, diagnostics and management. An unacceptable rise in ‘trolley waits’ by the mid to late 90s was evident. This was attributed to the ageing population and their increased attendances to EDs (Munir 2008). The aim of the four-hour policy was to reduce the waiting times and improve patient care (Munir 2008). While the emphasis on reducing waiting time and improving care through introducing the four-hour target was good in principle, it impacted on quality care and dignity. The lived experiences of participants in this study demonstrate this. What they are saying is that to fully appreciate the benefits of the four-hour policy requires other resources, such as appropriate nurse staffing levels, supportive managers and availability of beds in the hospital to move

patients to. Otherwise, EDs are stretched to the limits and the dignity aspect of the care is falling:

*'I think it's very good when there's beds, ED runs fabulously.....it doesn't matter how many people come through the door we work fabulously. When there are no beds in the hospital I think that's when dignity starts to drop....with the four hour targets to meet its rush, rush and things get forgotten.....'* (Nurse 9)

Literature directly exploring the impact of poor staffing levels or other work-related pressures in the ED on compromising patient dignity is scarce. A recent study by Ball et al (2013) examined the effects of lower nurse staffing levels in hospitals on impact of patient care. While this study was not exploring the impact of poor staffing levels on dignity, the findings do have some bearing on the current study as it supports the view that poor staffing levels can impact on the quality of the care provided. The authors conducted a cross-sectional survey of 2917 registered nurses working in 401 general medical/surgical wards in 46 acute NHS hospitals in England. The nurses were asked to choose what was left undone out of a list of 13 care activities. Several of the care activities on the questionnaire included: adequate patient surveillance, adequate documentation, comfort or talk with patients, administering medications, pain management and undertaking treatments/procedures. The authors found that 86% of nurses reported that one or more care activity had been left undone due to lack of time. The care activity most frequently left undone was comforting or talking to the patients. This was found to be associated with the number of patients assigned per registered nurse (RN). Staffing levels varied considerably among wards and hospitals. The average (mean) number of patients cared for per registered nurse was 7.8. As the number of patients per RN decreased, so did the amount and occurrence of missed care. The authors concluded that there was a strong relationship between RN staffing levels and the quantity of care being left undone. This was perceived to adversely affect care quality and safety (Ball et al 2013).

A small number of studies exploring health professionals' views of dignity in other care environments further confirm that work pressures can compromise older patients' dignity. The RCN conducted a large survey of its members to gain their perspectives regarding the maintenance and promotion of dignity in everyday practice (Baillie et al 2009). There were 2,048 respondents, out of which 1,110 worked with older people. Respondents included qualified nurses in various roles such as sister, staff nurse or clinical nurse specialists and healthcare assistants. The respondents reported that budgetary pressures and NHS targets were barriers to delivering dignified care. A number of respondents highlighted that even though everyone knows that dignity is the right thing to do and it is seen very much as a "nursing thing", it was overshadowed by the need to meet targets and financial balance. Several respondents further reported that managers were unsupportive in promoting patient dignity. They believed some managers lacked understanding of patients' care needs, and were more interested in meeting budgetary, and NHS targets than patient care needs (Baillie et al 2009). Furthermore, those respondents that worked with older people commented that poor staffing levels and high workload affected the time available to care for patients and maintain their dignity. Due to lack of time and inappropriate staffing levels, respondents highlighted that patients were not treated as individuals but as tasks (Baillie et al 2009). The findings of this survey resonate with the experiences of the participants in the current study.

The findings of this study and those of others arguably suggest that unsupportive managers, not only impact on the quality of care nurses provide but also influence the dignity of older people (Baillie et al 2009; Nystrom et al 2003). Several participants in this study have expressed how managers are more concerned with meeting specific targets rather than supporting nurses from doing what they came into nursing for and want to do, which is provide individualised patient care that enhances dignity. Furthermore, they expressed the view that the four-hour target is a hindrance to providing dignified care. The

impact of the four- hour target was explored in a qualitative study of nineteen ED nurses, using in-depth interviews by Mortimore & Cooper (2007). The authors described that all participants felt they were under immense pressure from the management for managing patients within the limited time frame. Participants also raised concerns that the quality of care was compromised by time targets taking priority over clinical needs of the patient. This key feature is also reflected in the participants' accounts in this study. Similar issues were raised in the Mid Staffordshire NHS Foundation Trust inquiry by Sir Robert Francis (2013). The report identified that the hospital culture focused on doing the system's business - not that of the patients (p4), the trust prioritised its financial implications over its quality of care, and failed to put patients at the centre of its work (p45) and this is echoed by several participants in this study directly relating to dignity.

#### Staff Attitudes and Perceptions of Older People

This subtheme relates to how staff perceptions of older people can influence dignified care. Several participants insinuated that some nurses assumed that older people are mostly confused and lacked understanding and this was regarded as inappropriate. For example, the following participant observes how some nurses speak down to older people and how she would feel if this was a member of her family:

*'I think some people talk down to older people and assume that they are all a little bit scatty because they are old. My parents are quite elderly and I wouldn't want them spoken to as they were not right. My dad is eighty but he is very fit and well, I wouldn't want him spoken down to just because of his age.'* (Nurse 4).

This participant further elaborates:

*'It's important to speak to each patient on an individual bases.....just because they are elderly don't assume their understanding of the situation. You quite often get a ninety year old who is fit as a fiddle and as bright as anything so I wouldn't assume they are confused just*

*because of a certain age because that is condescending.....' (Nurse 4).*

Another participant stated that nurses often did not see older patients as individuals in ED and referred them to as an 'old man or lady':

*'I think other nurses sometimes don't see older patients as individual people, and will refer to them as that's just an old lady or just an old man .....' (Nurse 6).*

While several participants discussed this in relations to the attitudes in ED, one participant recalled incidents of attitudes of other staff in the hospital towards older people:

*'It makes me feel terrible, nursing is about compassion and enhancing dignity and it's just not being met. There have been incidents where I have been handing over patients from ED over to wards and as soon as I say their age, they ask if they are a wonderer or confused.....I think it's all about attitudes and culture within people' (Nurse 8).*

Help the age (2002) states that ageism is the most common form of discrimination in the UK. Ageism can occur in any socio-cultural context, including health care. Ageism in health care can be expressed in a variety of ways including, stereotyping about the physical or mental ability of the older person. In exploring the meaning behind the above narratives, it is possible that some participants are stereotyping older people, with the assumption that they are confused and lacking in awareness. A lack of regard for older patients' physical or mental ability threatens their dignity. Participants making such assumptions about older people and communicating with disrespect demonstrates their disregard for the maintenance of dignity. How older people should be addressed was recognised as an essential component of dignity. A small number of participants reported that older people should not be addressed by their Christian names or as love or darling. This was seen to endanger dignity.

*'Dignity is about how you address older people. I think you should think about who you are addressing. Often nurses don't ask what the patient*

*want to be called, they presume they can be called by their first name, whereas a lot of older patients prefer Mrs or Mr'. (Nurse 8).*

*'Dignity is also about how older patients should be addressed.....first name terms or surnames.....and in ED, well it sounds awful but sometimes we don't tend to ask older people what they want to be called and call them by their first name. You forget that older people, like my Nan, like to be addressed as Mrs. She was always known as Mrs..... To all her neighbours so when she came into hospital she did not respond to being called by her first name'. (Nurse 2).*

In health care and in society in general the age of a person has come to be a benchmark by which he or she is valued or devalued. The last two decades has seen the term 'ageism' applied to and referred to negative attitudes held by individuals who are involved with the care of older people. Older patients themselves believe that ageism is rife within society (Bayer et al 2005). Literature exploring older people's views of dignity indeed highlighted this. Woolhead et al (2004), using qualitative methods, explored the concept of dignity from the older person's perspective. Focus group discussions were used as the main method of data collection. The groups were held in cities in South West England and South Wales. Participants were chosen to represent a mix of socio-economic status, ethnicity, gender, age (65 and above) and level of fitness. Seventy two older participants were involved in fifteen focus groups. The authors described that participants felt that the visible signs of ageing lead to disrespect from others. For example, participants stated that grey hair made people feel anonymous, or treated as a child. They reported that participants found disrespectful labels attached to old age such as 'cotton buds' and 'geriatric' was degrading and jeopardised their dignity (Woolhead et al 2004). While participants in this current study did not use such labels to show disrespect or stereotype older patients, other forms of labels were evident. The use of words such as that of 'old lady or old man', and talking down to older people are not only ways of stereotyping people but also showing negative



attitudes. The findings of this current study support what older people themselves believe are evident in society in relation to ageism, negative attitudes and stereotyping (Woolhead et al 2004).

Bayer et al (2005) in their European study of older adults reported that in care situations, participants indicated that the attitude of professional staff was vitally important in dignifying care. Moreover, all participants in each country discussed that poor communication practices of health care workers compromised their dignity. Poor communication practices, especially the patronising and disrespectful manner in which older people were addressed using first name or pet names, such as 'dear' or 'love', or the way they were ignored was cited as diminishing dignity (Bayer et al 2005). Interestingly, there are similarities between the attitudes expressed by older people in these two studies (Woolhead et al 2004; Bayer et al 2005) and those of participants in this study.

Studies have also investigated health care workers' attitudes towards hospitalised older people which further show similarities to the attitudes and perceptions expressed by the participants in this current study. McLafferty and Morrison (2004) explored the attitudes of nurses working in medical surgical wards, nurse teachers and student nurses. This was a qualitative study using purposive sampling of nine Registered nurses from care of older adults' area, four from acute areas, six nurse teachers, and seventeen second-year nursing students. Data was collected through focus group interviews, using video-recorder. Data was transcribed verbatim and analysed thematically. Ten themes emerged from the data, although only five were described in this published paper, being the ones that produced most discussion in the focus group interviews. Out of the five themes, one theme, labelling older adults, has particular relevance to this study. The authors described how labelling or stereotyping was discussed amongst all focus groups. Participants in the student nurses group discussed how they had noticed nurses stereotyping older people. They described nurses being patronising and infantilizing older adults

by calling them 'dears'. Another participant said that nurses didn't always bother to learn the names of older adults. In fact, some student participants further elaborated that the nurses called older adults admitted to the wards 'old wrinkles'. The authors further reported how nurses held negative images and perceptions of older people. Several student participants conveyed that they had observed nurses on wards describing older adults as 'cantankerous', 'grannies' or more readily labelled them as 'confused' (McLafferty & Morrison 2003). It is possible that participants in this current study may hold negative image and perceptions of older people and mirror those of previous studies. Negative attitudes and poor perception of older people held by nurses inevitably have an impact on the quality of care provided and on maintenance of dignity. The present study further confirms the findings of Heijkskjold, Ekstedt and Lindwall (2010). This hermeneutics approach study explored nurses' experiences of patients' dignity in Swedish medical wards. Twelve participants were interviewed. The authors found that patients were not always approached as adults, but as children. This was related to the language nurses used to communicate with patients and exhibiting a behaviour that was more geared towards children than adult. Participants regarded this as violation of patients' dignity.

#### Patients with Dementia

Almost all participants spoke of how the dignity of older patients with dementia was compromised. These experiences mostly related to poor staffing levels, attitudes of staff and the challenges nurses face in their attempt to maintain dignity:

*'If the patient has dementia often their safety and dignity is compromised. Patients with dementia keep taking off their clothes, uncovering themselves or wondering around the department where other patients and relatives can see them. We haven't got the staff to cope with one-to-one care that these patients require as we have so many patients to look*

*after.....I think we could improve our care of the dementia patients’.*

(Nurse 1)

And

*‘.....often you will get elderly patients who have dementia but are also very sick and dignity of the patient sort of tends to slide a little because you are more concerned about meeting their health needs instead of trying to protect their dignity.....’.* (Nurse 3).

And

*‘It is very difficult to maintain a confused patient’s dignity.....they wonder out of cubicles and rip their gowns off or are trying to climb over the bed frames. Often they are alone with no family member or carer with them and come to an environment where they are vulnerable, confused and can’t communicate with us...’* (Nurse 2).

A participant expressed concern that often nurses’ attitudes towards patients with dementia were different and it was very frustrating to provide the level of care required to maintain dignity:

*I think there is a huge stigma attached to dementia..... everybody rolls their eyes.....the dignity of patients with dementia is different.....nurses get very frustrated because often patients with dementia are disorientated, anxious and usually require a one to one nursing which you can’t provide in an acute area.....there’s just not the staffing levels all the time so they are just left on the trolley.....’* (Nurse 8).

The National Dementia Strategy (DOH 2009) defines dementia as an “*Illness in which there is progressive decline in multiple areas of function, including decline in memory, reasoning, communication skills and the ability to carry out daily activities*”. It is estimated that dementia affects over 820,000 people in the UK and one in four inpatients in hospitals have some form of dementia (Sampson et al 2009). There is no doubt that the ED is often the first point of contact for patients with dementia accessing emergency medical or surgical care (Farrelly 2014). Clearly, some participants in this study are saying that they are finding it difficult to maintain the dignity of older people. They are describing the

emergency environment as unsuitable for people with dementia. Other factors such as poor staffing levels are also cited in the narratives. A recent literature review of clinical care of persons with dementia in the ED further supports the findings of this study. Clevenger et al (2012) conducted a literature review of studies relating to the clinical care of older people in the ED setting. Clinical care included steps to diagnose and treat acute illness such as assessment, medical management and nursing interventions performed during the visit. Seven studies published between 1995 and 2009 were reviewed. The ED care environment was identified as not being conducive to the care of older patients with dementia. The EDs were described as units which are often located in lower sections of the hospital without windows or sources of light. The open design of the ED was seen as more effective for the acutely ill patients, a design that produces a bustling, overpopulated, and a noisy place, and not at all suitable for the needs of older patients with dementia.

Moyle et al (2010) explored the perceptions of medical and nursing staff of their current practice in the care of older people. This was an Australian study, using a descriptive qualitative approach. Data was collected through semi-structured interviews with thirteen staff. These included a gerontologist and nursing staff. Several themes were described in the published paper: defining confusion, everyday challenges, cultural barriers, and optimal care practices. The authors described how participants talked about the challenges they encountered when working closely with older patients with dementia and were confused. Participants displayed negative attitudes towards people with dementia. A common concern expressed by the participants was their perception that hospital management did not show they cared about staff having to manage aggressive patients. The theme cultural barriers related to the physical environment where care was provided. Participants felt that the focus of the acute care environment was strongly geared towards acute problems, and patients suffering from dementia were viewed as low-priority cases. More significantly, participants felt there was little time available for people with

dementia in the busy acute care environment. They further felt the model of care adopted within the acute care environment focused on safety rather than basic nursing care and meaningful interactions. Participants also acknowledged that the care provided to patients with dementia was sub-optimal and there was a need for a better care delivery to people with dementia (Moyle et al 2010). Several of these findings indeed mirror what the participants in the current study have highlighted. While Moyle et al (2010) study was not directly exploring health professionals' views and perceptions relating to dignity of older patients with dementia, the findings suggest that issues identified by the participants are similar to those of the participants in this study. In the face of paucity of evidence available on the dignity of older people in the ED context the findings of this study at least makes a noteworthy contribution to the evidence base.

EDs are and no doubt will continue to be the first port of call for older people, including those with dementia accessing emergency medical care. Many of the older patients attending ED will not only have dementia, but may have other conditions such as infection, trauma, dehydration and polypharmacy that can cause further cognitive impairment or delirium (Andrews & Christie 2009). The participants in this study understand the vulnerability of these patients and also recognise that providing dignified care is their priority. However, it is evident from their experiences that the environment in which they work, is not conducive to the needs of the older patients and they face a number of challenges that impacts on dignity.

In the UK, The National Dementia Strategy (DOH 2009) and more recently former Prime Minister's Challenge on Dementia (2015) set out initiatives in raising dementia awareness, earlier diagnosis and interventions, and higher quality of care across health and social care. Other initiatives, such as the RCN's (2013) five principles of improving dementia care in hospitals, further provide nurses with educational resources to improve the care of older patients. However, interviews with the participants for this study were conducted in 2013,

when the implementation of the National Dementia Strategy was in its infancy and the RCN had not yet introduced its initiatives. Therefore, it is possible with the introduction and implementation of these initiatives, participants' experiences, perceptions and views may be different today.

### Environmental Constraints

This emerging subtheme related to caring for patients in specific areas of ED. This mainly involved the resuscitation area and the corridor. Participants viewed these as environmental constraints or influences of the department where they felt patients' dignity was often compromised. The resuscitation area is an open plan design efficient for caring for acutely ill patients. It includes a small number of beds, usually five, separated by curtains and the open design produces an active overpopulated, noisy space (Clevenger et al 2012) which participants confirmed can compromise patient dignity. This was seen to impact on a patient's privacy and confidentiality; in particular, this related to issues of toileting patients in the resuscitation area. Participants found no difficulty in citing examples of how dignity is compromised in this area:

*'Resuscitation area, that's probably one of the worst for dignity. The curtains are poorly fitted in each of the five bays. You can see the patient if they are toileted or if they are having any treatment' (Nurse 8).*

And

*'.....really you can't get privacy in resuscitation area. The fact you haven't got privacy visually or audibly you know they can hear what's going on in the next bay...' (Nurse4).*

And

*'Dignity is completely out of the window in resuscitation area....we have sick patients.... we are trying to put on bedpans or commodes and there is no privacy as it is all very open and that's just not maintaining dignity...I do feel ashamed on how we are trying to deal with dignity in resus.....it's very poorly maintained'. (Nurse 3).*

And

*'Resuscitation area is a nightmare for patient privacy and dignity as the curtains don't actually meet the end of the bays so you have a wide gap. When you have to either change a patient or put the patient on the toilet it's quite exposed. There is nothing to block sounds so if you are talking to one patient everybody else can hear.....so that can be a bit awkward. If a patient uses a commode they've got very little privacy to do that and obviously sometimes without being ridiculous it can smell and the poor patient will get embarrassed' (Nurse 6).*

Helping patients to manage elimination and incontinence is indisputably part of bedside nursing care (Dean 2012). More significantly, it is part of basic nursing care. While the management of elimination is part of good basic nursing care, the above participants are highlighting several environmental issues that prevent them from performing this duty of care. Toileting of patients' in the resuscitation area is unavoidable because often patients are very ill and cannot be taken to the toilet. It is clear from the participants' narratives that maintaining privacy and confidentiality in these delicate situations is very important to them. The two core themes to emerge from the data analysis are interrelated. Privacy of the body was identified as an attribute of dignity and participants described their active efforts of preserving the privacy of the older participants. Nevertheless, participants' descriptions showed their awareness of how older patients' privacy is compromised due to the design of the resuscitation area and other resources such as poor fitting curtains.

*'I don't think there is any dignity in resuscitation area because there are five beds with only curtains to separate them.....anyone can see through curtains especially in the first bay.....that's where the ambulance doors are and there's people on the corridor looking in on you know if you are doing CPR on a patient. I think that's terrible and that's not dignity'. (Nurse 5).*

Privacy, as previously discussed is a basic human right and its integrity is reflected in the participants' narratives. Lack of privacy is associated with loss of dignity. The current findings associated with lack of privacy in ED add to the growing body of literature relating to factors that can hinder dignity in acute care settings. Matiti & Trorey (2008) also reported how older participants complained that badly fitting curtains compromised privacy and dignity. Baillie et al (2009) in reporting the findings of the RCN survey described how poor physical privacy was compromised due to lack of space and ill-fitting curtains, mixed-sex accommodation and inadequate facilities such nearby toilets were all barriers to dignified care. Even though the resuscitation area is a mixed-sex area of care, participants did not cite this as hindering dignity. Woogara (2005) reported similar findings. Data collection for this ethnographic study involved non-participant observation on medical and surgical wards and unstructured and semi-structured interviews with patients and nursing staff. The author observed that patients who were being cared for in bays had little privacy in relation to physical privacy and more significantly in relation to confidentiality. Patient confidentiality was constantly breached during doctor's ward rounds, and between staff and patient interactions (Woogara 2005). The current study further provides evidence regarding patient confidentiality. Several participants described incidents relating to breach of patient confidentiality in the resuscitation area:

*'Relatives and other patients can hear everything you are saying to a patient. They can hear every conversation when the doctors are assessing patients or when patients are on commodes. Resuscitation area is the only area in ED that hasn't got private cubicles and is the worst area for patient dignity'. (Nurse 1).*

And

*'What's more patient notes are left lying around and when you are handing over to a ward or discussing patient care it's overheard by everyone'. (Nurse 8).*



And

*'There isn't much privacy or confidentiality for patients as bays are close together with just curtains between them. I remember an experience where we had two patients from a car accident brought into resuscitation area. A female patient was in one bay and the other lady who had caused the accident was in the next bay. The family of both patients could hear what was being said in each cubicle.....everyone could hear everything.....it's not much privacy at all and that really upset me.....'* (Nurse 5).

One of the most unanticipated findings of this study related to nursing patients in the ED corridor and how this impacted on dignity. Nursing patients in corridors takes place when EDs are overcrowded. Emergency department overcrowding has been defined as an ED operating beyond its available capacity, which results in a situation where demand for emergency services exceeds the ability of a department to provide quality care within acceptable time frames (Hoot et al 2007). Emergency department overcrowding is cited as primarily due to shortage of inpatient beds in the hospital (Gilligan & Quin 2011). When hospital wards are full, no patient in ED who is awaiting admission can be admitted. While the full wards don't admit new patients until a bed becomes available, ED doors do not close. Patients will continue to arrive in the ED, even if all cubicles and areas are full (Cessford 2005). When this happens, patients are lined up in the ED corridor waiting for a cubicle or a bed to become available on the wards. The overcrowding of EDs is a global issue, affecting almost all EDs in western countries. In the UK this is now considered a crisis proportion since the dawning of the new millennium (Coghlan & Corry 2007). The following participants in the study describe situation of having patients in the ED corridor and issues that concern them:

*'In ED we have a corridor before you actually get into the main department and cubicles. Often this corridor is literally head to foot with beds with patients on them. We've had up to twenty-three patients in the corridor so there is no privacy or dignity on the corridor. There is no*

*screening there is no room to put anybody into. Everyone can hear what's happening to everybody'. (Nurse 8).*

And

*'Since we started to nurse patients in the corridor whilst they are waiting to get into cubicles, I feel that care is compromised. It is not dignified and it's not nice to see patients in the corridor, especially if they have been there for a few hours'. (Nurse 1).*

And

*'Yes the biggest problem in the corridor is maintaining the privacy of conversation.....' (Nurse 4).*

*'There is no privacy or confidentiality in the corridor..... and majority of the patients in corridor are elderly'. (Nurse 3).*

The most significant factors that concerns the participants regarding having patients in the corridor relates to the lack of privacy, confidentiality and lack of appropriate facilities such as toilets. The NMC (2015) in the code for professional standards of practice and behaviour stipulate that as a nurse or midwife: *"You owe a duty of confidentiality to all those who are receiving care"* (p6). From the participants' narratives it is clear that they understand that the responsibility of safeguarding the privacy and confidentiality of patients rests with them (Wainwright 1995). However, what is also evident that in practice, safeguarding privacy and confidentiality in the corridor is difficult to achieve (McParland et al 2000). Privacy and dignity are important human needs. As such every older patient has the right to experience them. Equally, every nurse has an obligation to provide the conditions for their achievement (Whitehead & Wheeler 2008). Therefore, there is a conflict between what the participants know the care of patients should be and what they would like to deliver and in reality what they are able to deliver in the corridor. Moreover, it is also clear that participants have a high regard for privacy and confidentiality. There is very little literature regarding the perceptions of nurses and patients on the issue of privacy and dignity within the emergency care context.

A Swedish study (Back & Wikblad 1998) explored patients' and nurses' attitudes towards privacy in acute hospital. One hundred and twenty patients and thirty eight nurses completed a questionnaire that included twenty questions related to dignity. The authors reported that nurses and patients agreed in the rating for privacy in general. Privacy in hospital was estimated more highly by the nurses than by the patients. However, Back & Wikblad's (1998) study did not investigate if the privacy needs of patients were achieved in the acute environment or if there were factors that impacted on privacy (Back & Wikblad 1998).

Lack of appropriate resources such as toilets within the corridor was constantly cited as a factor that hindered dignity in this study. Participants had no difficulty in describing the continued issue associated with privacy and care in the corridor. In fact it was overwhelming listening to their narrative accounts of the difficulties associated with this:

*'.....there are no toilet facilities. Older people often need the toilet and they need to go straight away. It's very difficult sometimes to provide the dignity that's needed for somebody to go to the toilet'. (Nurse 8).*

*'Patients are in the corridor where everyone can walk past and see them....and it's not private or dignified because you know if that person is vomiting or you know got a nose bleed people stare and look at you.....that's not dignified...' (Nurse 5).*

From the participants' stories, it is clear that they find it difficult to achieve the reality of providing individualised care that enhances dignity in an overcrowded ED where patients are cared for in a corridor. As previously discussed, overcrowding of EDs is not a new phenomenon. Since the beginning of the new century, numerous high profile news headlines have reported the overcrowding of British ED departments. In a newspaper report, Dr Clifford Mann, president of the College of Emergency Medicine, suggested that overcrowding can have a detrimental effect on patients (The Guardian 24<sup>th</sup> January 2015). Several studies have explored patients' and nurses experiences of overcrowding.

Kilcoyne and Dowling's (2007) interpretive phenomenological study explored nurses' experiences of working in ED to highlight nursing issues associated with overcrowding. Using purposive sampling, eleven nurses working in ED were recruited and interviewed. The participants reported that the ED is neither designed nor has the facilities for nursing patients for long periods. Furthermore, the participants highlighted that in an overcrowded ED, there is an illusion of nursing care being provided to patients, which in reality is not the case. Moreover, the sense of frustrations the participants felt in failing to provide quality care and their empathy for patients' lack of privacy and dignity resonates with participants in the current study. Several participants in this study conveyed feelings of embarrassment, frustration and empathy for the older patients as reflected in the following narratives:

*'I felt embarrassed for the patient and embarrassed that I was in a situation that I couldn't care for the patient properly. I felt angry .....I wasn't doing my job properly because it took me so long to find a cubicle to get this patient toileted. I had to apologise to the patient and relatives'.*  
(Nurse 1)

And

*'I feel really bad you know it's something that you wouldn't want somebody not to be able to go to the toilet and not to be able to provide some facilities for them'.* (Nurse 8).

And

*'I feel embarrassed when I have to work on the corridor.....there isn't any dignity...for an elderly person to be waiting hours on a corridor, I don't think that's dignified at all really'.* (Nurse 5).

The theme of embarrassment and frustration at having to look after patients in the corridor was evident in all the participants' narratives. Feelings of powerlessness and anger at not being able to maintain older patients' dignity in such surroundings was further apparent. It was further obvious that participants hated working in the corridor, due to the impact it had on patient dignity:

*'It's not acceptable and it is hard on the nurses that are looking after the patients because they are appalled, they are embarrassed to say that they are part of the NHS. I don't set out to look after patients in that way and I do my best for the patients.....it is so disheartening..... I find the elderly patients feel that they are forgotten, they feel, well, they are old and they know that they have not got long to live, you'll hear them speak and say, oh, they (nurses) are not bothered, we're old. It's not that and you know we do our best to make them comfortable but you can't maintain their dignity in the corridor'.* (Nurse 2)

And

*'Treating patients in the corridor.....it's out of the nurses' control, we have got no power over that at all and it shouldn't happen and you know some of patients could be on the corridor for hours past the four hours'.* (Nurse 2).

And

*'I don't like nursing patients in corridors and I don't believe in nursing patients in corridor.....'* (Nurse 1).

Holistic, individualised care that enhances older patients' dignity is seen as ideal. However, the effects of overcrowding, whereby patients are being nursed in corridor appears to pose serious concerns for the participants. The participants in this study, especially in situations which are out of their control, may be experiencing initial moral distress. Initial moral distress involves 'the feelings of frustration, anger and anxiety people experience when faced with institutional obstacles and conflict with others about values' (Jameton 1984 cited in Johnstone & Hutchinson 2015). The cause of this moral distress in nursing lies with three key areas: clinical settings or issues such as difficult care decisions, inner restraints, for example inability to act in specific situations and external restrictions whereby management policies and priorities can contradict with individual client care needs (Johnstone and Hutchinson 2015). The construct of moral distress relies on the conjecture that there is a mismatch between what nurses' know to be the right thing to do and some forms of

constraint that prevents them from taking proper action (Johnstone & Hutchinson 2015). From the participants' experiences, it is apparent that it is the external constraints, of fiscal pressure on the emergency department and demands to contain service and poor staffing levels that prevent them from providing holistic individualised care that enhances dignity.

The concept of moral distress among ED nurses has been explored by a number of researchers. Wolf et al (2016) in an exploratory qualitative study explored the experiences of seventeen ED nurses regarding the nature of moral distress. Data was collected through semi-structured interviews. The two most prominent themes to emerge from the data were: challenges of the ED environment and being overwhelmed. Participants described their ED environment as “dysfunctional practice arena”. They described situations in which patient care was compromised by the multiple, often conflicting demands placed on nursing staff. They strongly spoke about the distress they experienced because they were unable to provide the level of care they felt patients deserved, in spite of being capable of providing that care, they often were prevented from doing so because of “unrealistic expectations” and a focus on metrics (Wolf et al 2016). Participants further identified “being overwhelmed” as a major driver of moral distress resulting in feelings of powerlessness, guilt, fear, anger, and frustration. These feelings are similar to the feelings expressed by the participants in the current study in relations to caring patients in the corridor. In fact, the participants in Wolf et al (2016) study described time pressures due to benchmarking metrics, volume-heavy, resource-depleted ED environment in which they attempted to provide an appropriate level of care. In similar to the participants in the current study, this was identified as a system issue, which they found even more distressing because of feelings of powerlessness to make systemic changes (Wolf et al 2016).

The participants in the present study reveal that dignity of older people is important to them, and understands what constitutes dignified care. However

several environmental constrain prevents them from delivering the dignified care they know patients deserve and which they are capable of delivering, but are unable to deliver.

### **Summary**

The participants in this study reveal their perceptions and understanding of older people's dignity from the emergency care perspective. The participants' accounts of their experiences of caring for older people and dignity were embedded within their life-world in one ED. Their voices, experiences and perceptions of dignity convey that dignity is an important component of their nursing care. However, several factors such as not having enough time and issues relating to the environment that they work in were seen as barrier to facilitating dignified care.

## **Chapter 5: Conclusion**

### **Introduction**

This chapter brings this thesis to a close by considering the study limitations and the implications of the finding for practice. How the findings of the study will be disseminated is also presented.

### **Limitations of the Study**

Descriptive phenomenology as a research methodology was selected to explore the lived experiences of emergency care nurses caring for older people in one ED, to understand their perceptions of older people's dignity. As very little was known about ED nurses' perceptions and understanding of older people's dignity and what constituted dignified care, this methodology provided structure and guidance to the study. This enabled the researcher to seek out the lived experiences of ED nurses caring for older people in ED to discover and describe their perceptions and understanding of dignity and factors that can facilitate or hinder dignity in the context of ED.

While the findings of this study provide an understanding of ED nurses' perceptions and understanding of dignity, they are subject to a number of limitations. One of the main limitations is inherent to the research approach. Several researchers emphasise that phenomenology as a research method is difficult to understand and adopt as a framework for conducting nursing research (Norlyk & Harder 2010; Converse 2012). Therefore, my own understanding and interpretation of phenomenology as a philosophy and a research method could be a significant limitation. I was guided and supported by experienced academic staff within this professional doctorate degree programme. While I also read extensively on different schools of phenomenology, I was a novice researcher, undertaking my first research study and utilising this complex methodology for the first time. Therefore, the debate associated with adopting phenomenology does make me question if I



misinterpreted any of the key issues surrounding descriptive phenomenology. However, I made every effort to understand the different approaches to phenomenology and utilise the most appropriate approach as demonstrated in the thesis. Norlyk and Harder (2010), following a review of several phenomenological studies in peer-reviewed nursing journals recommend the minimum criteria that should be addressed in a phenomenological study. They include: Identification of the philosophical assumption on which the study is based, an articulation of methodological keywords and, how an open attitude is adopted and maintained throughout the research process. I believe these were addressed within this study. Some researchers imply that it takes several years before a researcher can master the main elements of phenomenological research (Jones Porter 1998 cited in Snow 2009). It is suggested that novice researchers can only conduct research that is 'inspired' by phenomenology, rather than being phenomenological (Jones Porter 1998 cited in Snow 2009). For many scholars or experienced researchers, this is probably not good enough and yet this leaves the novice researcher, like me, in a difficult position for it is not possible to know phenomenology unless one engages with it and learns from each attempt (Snow 2009). Whilst I don't claim to have become an expert, after one attempt, I do believe the descriptive phenomenological approach has allowed me to focus and explore a practice-based issue that is important for older patients, nurses and the ED organisation, at a deeper level than would be the case with using other qualitative methods (Snow 2009).

Whilst this study only focused on the experiences of qualified ED nurses, it is important to recognise that qualified nurses in the ED do not work in isolation. They are often supported by untrained staff such as healthcare support workers who form a significant part of the nursing team providing care to older people. The findings of this study do not represent their views and perceptions of dignity. It is possible that their experiences, view and perceptions of older people's dignity in the ED context, may be entirely different to those of the

qualified nurses. Therefore, this can be viewed as a limitation of the study as health care support workers were not included.

One of the most significant limitations of the study was that the study was located in the ED where I work in as a nurse. The issues and challenges associated with 'insider research' added intricacy to this research study and undoubtedly had the potential to impact on the study process. The decision to conduct the study in my workplace and the challenges and issues associated with 'insider research' were addressed through reflexivity. While caution is advised on carrying out research in one's own work setting (Holloway & Wheeler 2010: 65), the professional doctorate degree is associated with the acquisition of knowledge and research skills to further advance or enhance professional practice. A key element of this degree is the investigation of a professional practice issue and the generation of new knowledge and expertise, using research strategies developed and applied by the professional practitioner themselves, while practising in that setting (Lee 2009: 10). Therefore, it was also important that I fulfil the key element associated with undertaking a professional doctorate degree.

The aim of this research study was not to develop a theory, but to explore a practice-based area relevant to my professional practice. Exploring ED nurses experiences to describe their perceptions and understanding of older people's dignity and the factors that can facilitate or hinder dignity in ED, extends our knowledge of dignity in this specific context that had not been previously explored. Although the findings of this study are not generalizable to other EDs as in the positivistic traditions of research, the emerging knowledge (Lee 2009: 34) is relevant to the participants involved in the study and the ED in which the study was located. As Lee (2009: 34), opines, professional doctorate studies are often concerned with the 'particular' rather than the 'universal'. This study involved taking an aspect of practice-based issue, previously only investigated from other perspective and embedding it in my own professional practice and context. Thus, the aim of this study has been achieved in that new knowledge

regarding ED nurses' perceptions and understanding of dignity and factors that impact on dignified care in the ED setting has been generated which has implications for delivery of patient care.

The final limitation of this study is that it involved a small number of participants. However, literature on phenomenological research does not offer definitive advice on sampling numbers. Sample size is not considered to be an intrinsic feature of phenomenological study. The sample size was guided by two principles as previously discussed, recommended by Polit & Beck (2014) and Creswell (2007). All participants were selected because they had the experience of caring for older people in one ED and were able to reflect, articulate and describe these experiences. A sample size of ten experienced ED nurses was considered to be appropriate to provide sufficient in-depth information in order to fully describe the phenomenon of dignity (Fossey et al 2002). A large sample was unnecessary in this study, as its intention was to provide insight to nurses' understanding and perceptions of dignity in one ED. As Holloway and Wheeler (2010: 146) believe, a larger sample size does not determine the importance of the study or the quality of the data. In fact they believe it usually results in less depth and richness and does not capture the meanings participants ascribe to their experience.

### **Essential Structure of ED Nurses' Experiences of Older People's Dignity**

Nurses' perceptions of older people's dignity in the ED setting related to actions inherent to autonomy. To the ED nurses, dignity meant seeing and treating the older people as unique individual human beings, who should be respected and valued. Dignity was seen and understood to be related to paying attention to and valuing the individual needs of the older people, especially during nursing care provision. Older people were recognised to be vulnerable when attending ED, due to their age, illness and ability. Nurses believed that it was their duty and responsibility to protect and preserve the dignity of older people who were often vulnerable and totally or partially dependent on them for meeting their

care needs. Dignified care was seen as maintaining and protecting the privacy of older patients during nursing care. Providing nursing care that reinstated dignity was considered to be a nursing priority and valued as the main role of the nurses. The nurses experiences of caring for older people and their perceptions and understanding of dignity was entrenched within their ED life-world. Nevertheless, their experiences also highlighted that within this particular ED, older people's dignity was severely hindered by the complex care environment.

The ED as a care environment was identified as not conducive to providing care that promoted dignity. Lack of appropriate facilities, such as toilets and poorly designed care areas as the resuscitation area, hindered patients' privacy and dignity. Whilst the poor design issues were out of the nurses' control, other issues such as managerial pressures and poor staffing levels constantly impeded on delivering the type of care that promoted dignity. Poor staffing was regularly seen to impact on the care provided to patients with dementia. The dignity of patients with dementia was often compromised as nurses conveyed that they did not have the time or appropriate number of nurses to meet the individual care needs of these patients. ED culture was described as a system that valued and focused more on meeting specific government targets, rather than meeting the individual needs of the older people that facilitate dignified care. Privacy, as an attribute of dignity, facilitated or hindered dignity and was a thread that continued to cause concerns to the nurses in this ED. Lack of privacy when caring for patients in the corridor made nurses feel embarrassed, angry, and frustrated. The nurses knew that holistic, individualised nursing care not only enhanced patients' dignity, and was what they believed older people deserved. They found it disheartening that while they were capable of delivering this care, they were unable to do so, due to the complex ED environment in which they work.

### **Implications for Practice and Recommendations**

The findings of this exploratory study are only specific to the study site and the individuals involved. However, these findings are new and innovative as the phenomenon of dignity has not been previously studied from the emergency care perspective. The findings have different stakeholder implications including the hospital Trust, its board, the strategic and operational management team of the ED, all staff working within this particular care setting and older patients. Seen from the ED nurses' perspective, while dignity of older patients was important to them, a number of factors such as environmental constraints prevented them from delivering dignified care. As an organisation, this Trust and its board, strategic and operational managers and lead ED nurses need to address these dignity-inhibiting environmental issues, so that nurses who provide nursing care to older people every day in this complex environment can endeavour to promote their dignity. The issues that need to be addressed include:

1). The ED environment was described by the participants as unsuitable for caring for patients with dementia. They felt that the acute care environment was not favourable to maintain the safety and dignity of patients with dementia. Due to environmental constraints, often poor staffing levels and the number of patients allocated per member of staff, participants encountered a number of difficulties in providing individualised care to patients with dementia.

Experiences of poor care in ED, is associated with an increase in stress and anxiety amongst older patients who already have a number of communication difficulties (James & Hodnett 2009). Emergency departments will continue to be the first point of contact for patients with dementia seeking health care. Due to the fast pace and complex nature of the ED, whereby loud noises and overcrowding is a common occurrence the ED is a challenging area to provide individualised nursing care to patients with dementia. In view of the study findings it is imperative that this Trust, its board and the ED consider ways of creating an environment in which these patients can be cared for with empathy

and their dignity maintained. A recent campaign by the Alzheimer's Society (2016) called: *Fix Dementia Care in Hospitals* recommend a number of initiatives for hospitals to adopt in order to improve the care of patients with dementia: Creating dementia-friendly environment and implementing fast-track admission pathway for patients with dementia are two of the recommendations that could be introduced within this ED.

Dementia-friendly environment from the emergency care perspective could be a designated cubicle within the ED which is quite, reduces loud noises and aids tranquillity and thus creates a safe and private area for the assessment and care of patients with dementia. However, such initiative will require making physical changes to the designated cubicle, such as redecorating and changing clinical equipment which will have cost implications. Therefore, commitment of the hospital board and ED staff contribution is essential in making such changes. Evidence from hospitals where EDs have introduced 'dementia friendly' cubicles is positive and staff believe that it not only have a calming effect on patients with dementia, but it also allows them to combine the demanding work of emergency nursing with care and protection of dignity of (Farrelly 2009; James & Hodnett 2009).

It is further recommended that this ED and its stakeholders consider setting up a multi-disciplinary fast-track assessment and admission care pathway so that patients with or suspected dementia are quickly assessed and admitted to an appropriate speciality without a difficult wait in a dementia-unfriendly environment. All patients arriving to ED are triaged by senior ED nurses to assess their clinical condition and urgency. Appropriate dementia education and awareness training in conjunction with an integrated pathway will allow the ED nurses to triage patients with or suspected dementia appropriately, and ensure that they get a timely, comprehensive assessment and care that they deserve. Fast-track pathways are not new to EDs or the staff. There are numerous such pathways that are operational in almost all emergency departments. Developing

and implementing such care pathway will require the commitment of the Trust board and the involvement of health professionals from different multi-disciplinary specialities including acute medicine, gerontology, surgery and allied health professionals such as physiotherapist and occupational therapists. A multi-disciplinary integrated fast-track pathway will streamline and standardise the care of older patients with dementia and will be very effective in providing timely assessment, interventions, and specialised care.

In addition the ED nursing management needs to review the staff numbers required to deliver safe and individualised quality care of older patients. Issues relating to staff recruitment and retention must be identified and discussed with Trust management so that any pertinent issues are addressed effectively.

**2).** The ED environment/culture was described as a system that valued and focused more on meeting the 4-hour target rather than the individual needs of older people. It appears that the current culture of this ED is characterised by government initiatives aimed at reducing waiting times and not quality care. This appears to contrast with what nurses believe older patients need. To promote dignity, nurses feel more time is required to spend with patients instead of meeting targets. The constant impact of working to meet the government target and prioritising nursing care has the potential to demoralise staff and jeopardise individualised patient care. While meeting the 4-hour target is important, the Trust board and the ED management needs to seriously establish a method of appropriate communication with the staff members who are providing direct physical nursing care to older people every day. Open and effective communication will ensure that all members of staff are being listened to and their concerns regarding the issues of meeting targets and the impact it has on them and on the quality of care delivered are understood by the management team. Furthermore, Trust-wide engagement is essential to identify processes and procedures that can eliminate the current target focused culture, so that a new culture is fostered which puts the older patients and quality care at the foremost.

**3).** Lack of privacy, was described as compromising dignity in specific areas, such as the resuscitation area of the ED. The design of this area is not conducive to promoting privacy and confidentiality. Therefore some modification is required which have systematic planning and financial resource implications therefore may be impossible to achieve in the current state of health care. However issues of how privacy can be improved through practical measures are attainable and require an organisational approach. An observational audit of the resuscitation area and the corridor needs to be conducted to assess and benchmark the current environment standards and to identify new facilities or practical measures that can be implemented to promote physical privacy, especially in relation to toileting and toilet facilities.

**4).** Frustration, anger, embarrassment and feelings of powerlessness were reflected by the participants in having to care for patients in the corridor. Due to ED overcrowding, it has become a norm in the last decade to have patients in corridors. Nonetheless, nurses in this study reveal experiences of moral conflict as they are unable to promote dignity due to issues beyond their control. Moral conflict is associated with moral distress and burnout amongst ED nurses. Therefore, it is imperative the ED management team and the Trust recognise the implications of moral distress and the impact it can have on their staff. Interventions to promote staff morale such as supporting staff during periods of ED overcrowding is essential. Open and regular communication between the staff and management is vital in ensuring that staff feel valued and supported, thus reducing the potential of burnout amongst the staff.

The findings of this study have been discussed with the nurse manager and further disseminated with the rest of nursing and medical management team of the ED are ongoing. The findings of this study are being used to review the current practice of this ED. Informal discussions have already been initiated by the researcher with a senior gerontology nurse to consider the possibility of



developing an integrated care pathway. The issues and difficulties identified within the findings of this study are complex and multifaceted and will require all stakeholder involvement to address them.

### **Dissemination of Findings of the Study**

The study findings are being disseminated locally and nationally in addition to dissemination at the study site as outlined above. Locally, a poster will be submitted to the hospital's annual Research Conference. The findings will also be presented at Coventry University's Faculty of Nursing and Midwifery Research Seminar event. Even though the findings of this study cannot be generalised to other ED settings, nationally, I would like to share the findings with fellow ED nurses, who can decide for themselves if the findings are applicable to their own practice. Therefore, I intend to publish the findings of this study in a nursing journal relevant to the subject of the research. Journals I would most likely to consider publishing in include International Journal of Emergency Nursing or Emergency Nurse. A poster presentation has already been accepted at the RCN's annual International Research Conference.

### **Future Research**

This study has provides an insight and understanding of ED nurses' perceptions of older people's dignity in the ED and the factors that can facilitate or hinder delivery of dignified care. However, the findings of this phenomenological study cannot be generalised; therefore further research is necessary to provide in-depth understanding of older patients' dignity from the ED perspective. The findings presented in this thesis relates to the experiences of ten nurses from one ED. Nurses working in other EDs may have different experiences and therefore may have different perceptions and understanding of dignity. This study only sought ED nurses' experiences of dignity. It is imperative to explore the experiences and perceptions of dignity as perceived by other members of the multi-professional ED team. Dignity is subjective and it is the older patients who are the recipient of nursing care. Further research exploring older patients'

experiences of dignity in the ED context may present different perceptions and understanding of dignity.

### **Reflections on the Study and the Professional Doctorate**

Embarking on the professional doctorate degree and conducting this research study was both daunting and exciting. It was daunting, because I had no previous concrete experiences of undertaking any research projects. Despite being an experienced clinician and a lecturer in emergency care, I was a novice researcher and I had doubts about my ability to participate in research. Nevertheless, during the early years of this doctoral programme, through the taught modules and assessments, I developed the confidence to be able to combine the practitioner-researcher role, which is the key element of the professional doctorate study. The exciting part of this journey was investigating a topic that interested me, which had the potential to impact my clinical practice, setting and patient care. The most challenging and frustrating part of this study was data analysis. The quantity of data in terms of written words was overwhelming. Whilst the data analysis process involved procedural steps, numerous approaches such as mind maps, cutting and pasting, were utilised to work through the data. Support from my supervisor through this difficult, frustrating and challenging process was incredible. Despite the challenges associated with being a novice researcher, this research journey has developed my research skills beyond my expectations and ability. However, combining the role of practitioner-researcher does not end with this study. I have every intention to continue with this role, with the aim of contributing to the evidence-based practice within my discipline.

### **Summary and Final Conclusion**

This study explored emergency care nurses' experiences of caring for older people in one ED, to discover and describe their perceptions of dignity and the factors that can facilitate or hinder dignified care. The nurses' narratives of their experiences indicated that the dignity of older people is important to them.

Dignity was perceived as an approach to their nursing role focusing upon respect, individuality and choice. Further attributes of dignity related to respecting and maintaining older people's privacy during care delivery. Providing good nursing care that met individual patient needs was associated in enhancing dignity in the ED context. While ED nurses made every effort to facilitate dignified care of older people, several issues were identified that hindered dignity in the ED. Poor staffing levels, government targets and the overall design of the ED impacted on delivering dignified care. The majority of the findings of this study support the evidence of previous studies. Nonetheless, a number of issues relating to older people's dignity were specific to emergency care nursing and the environment. This related to patients being cared for in areas such as resuscitation and the corridor, where it was impossible for nurses to maintain older people's dignity. These findings, although rather disturbing, reveal the nurses' perceptions and understanding of older people's dignity as experienced by them in this ED.

## **Appendix A**

### **Literature Search Strategy, Selection and Appraisal Process**

A range of research literature relating to healthcare practitioners and older people's experiences in various health care settings was accessed, reviewed and critiqued, to provide comprehensive background for understanding the concept of dignity (Sui and Comerasamy 2013: 15; Cronin et al 2008). Flick (2014; 67) suggests that reviewing the theoretical literature in an area of interest should help answer such questions as to what is already known about the topic, what questions remain and what has not yet been studied. Thus, the aim of the review was primarily to:

1. Identify older people's perception of the concept of dignity
2. Identify health care practitioners' perception of the concept of dignity.
3. Discover how dignity can be promoted or compromised in health care.
4. Identify gaps in the evidence for further research.

#### **Methods**

Aveyard (2007: 65) suggests that when conducting a review, the first step is to identify keywords that capture the essence of the research topic or research question that is the focus of review. A combination of search terms, were identified to represent the sample population (older people/ patients, and nurses) and their experiences of dignity. These were: older people, patients, dignity, nursing, experience, emergency care, accident and emergency and hospital. Boolean operators such as AND, OR were used to combine the search terms together appropriately (Booth et al 2012: 76).

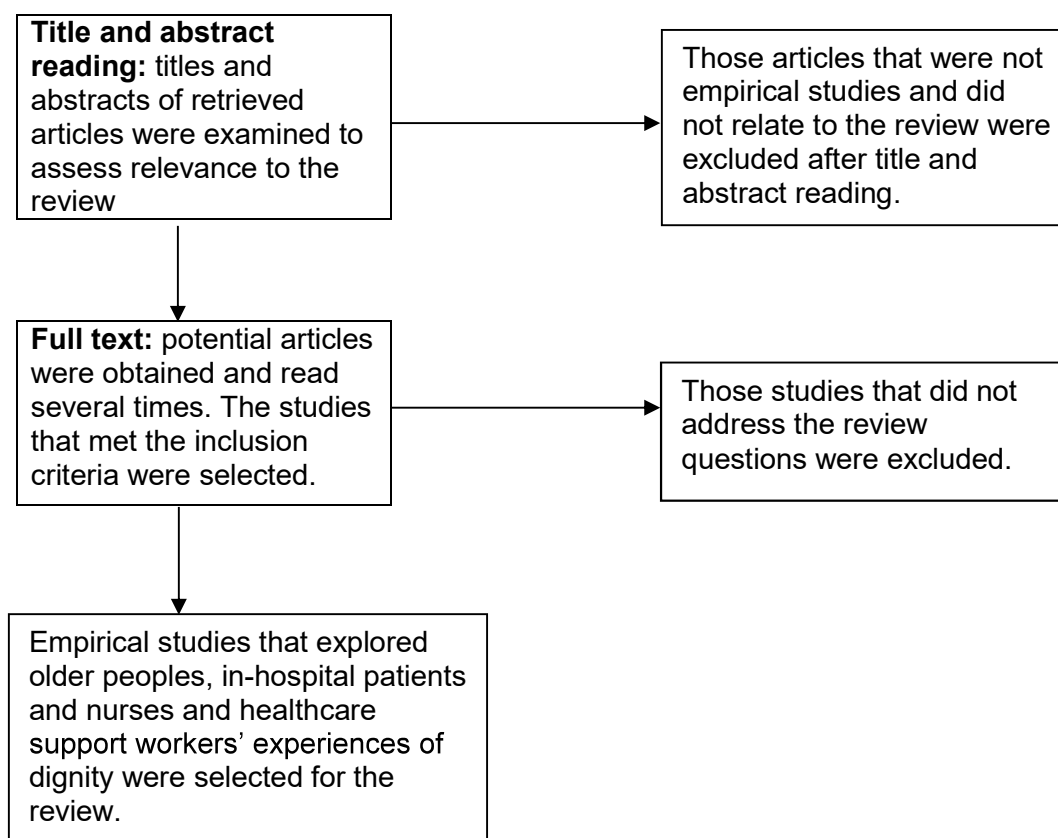
A systematic online search was conducted largely focusing on the electronic databases, CINAHL, MEDLINE, AMED & Cochrane). These databases include extensive journal articles from worldwide sources including several western countries, such as Europe, Australia and United States of America (USA). With the demographic changes of increasing numbers of older people in several western countries, the concept of dignity is not unique to UK. As a result, using

all these resources meant pertinent evidence relating to the review were not missed (Siu and Comerasamy 2013: 71). The literature searching was limited to studies published after 2000 and written in English only.

An inclusion and exclusion criteria to identify the literature that directly addressed the research questions (Aveyard 2007: 59) was established as follows:

Inclusion criteria	Exclusion criteria
<ul style="list-style-type: none"> <li>• Empirical studies using qualitative or quantitative methods exploring older people or older patients and healthcare practitioners' (nurses' health care support workers) experiences of dignity.</li> <li>• Studies that were published since 2000 (Lack of respect for dignity became a major issue at the beginning of the 21<sup>st</sup> century with several government strategies/policies introduced to prioritize dignified care).</li> <li>• Studies that were published in peer review Journals, written in the English language and published in western countries such as Europe, USA, Australia, UK and Canada.</li> <li>• Older adults/patients &gt;65 years</li> </ul>	<ul style="list-style-type: none"> <li>• Papers that were not empirical studies. This included discussion papers, personal opinions</li> <li>• Doctors' perceptions and experiences of dignity were not sought as nurses and health care support workers are the key nursing care providers in all western countries.</li> <li>• Studies published prior to the year 2000 were omitted as the evidence would be outdated and not relevant to the review.</li> <li>• Studies that were not published in peer review journals or not written in English were excluded.</li> <li>• Adult patients &lt; 65 years including children</li> </ul>

As well as searching published literature, information produced by agencies such as Age UK was also included within the review. This was useful in locating studies commissioned by the agency exploring older people's views on dignity which may not have been accessible by the databases (Booth et al 2012: 78). Help from subject librarians was also enlisted to ensure that the search terms and inclusion and exclusion criteria were appropriate. Utilising the inclusion and exclusion criteria all articles identified by the literature search, were screened to select those that were relevant to the review and this process is presented in the table:



Bibliographies and reference lists of all retrieved studies were further checked to ensure no relevant studies were missed, as electronic searching may miss important published studies (Booth et al 2012: 78) particularly when concepts are hard to define; so further steps were necessary to ensure identification of relevant studies. Studies directly exploring emergency care nurses or older

people's experiences of dignity in emergency care setting were not found. Studies relating to older people's experiences of accessing emergency services or waiting times in emergency care were found and were excluded as they did not reflect the objectives of the literature review or the current study. In total eleven studies were included in the literature review. Ten were qualitative and one was quantitative. All studies explored the concept of dignity, and how dignity can be promoted or compromised within care settings.

There is increasing recognition of the valuable contribution qualitative research can make to nursing knowledge (Houghton et al (2013). Yet, there is no consensus among qualitative researchers about what constitutes a good qualitative study and how these should be critically appraised (Aveyard 2007: 97). Despite this uncertainty, all papers were examined for methodological quality, very broadly using the Critical Appraisal Skills tool (CASP 2002), and Lincoln and Guba's (1985) framework for determining the rigor of qualitative. Using a critical appraisal tool to assess the quality of the studies was deemed to be constructive rather than using an unstructured approach or not conducting a quality assessment at all (Aveyard 2007: 96).

All studies selected and reviewed presented a rich description of the phenomenon of dignity from older people, patients and health care practitioners' perspective (Barker 2013: 105). Ten out of the eleven studies included for review were qualitative in design and used various methods to explore the phenomenon of dignity. Five studies (Walsh & Kowanko 2002; Webster & Bryan 2009; Hoy et al 2007; Matiti & Trorey 2008; Hall & Hoy 2012) used a phenomenological approach to explore patients and healthcare workers experiences of dignity. Phenomenological approach is used to discover and develop understanding of experiences as perceived by those living the experience to provide a deeper understanding of a phenomenon (Rebar et al 2011: 184; Creswell 2007: 62). Phenomenology allows researchers to gain

insights that inform practice strategies and enhance practitioners' understanding of, and sensitivity to, those they serve (McWilliam 2013:229).

Phenomenology is also a philosophy and there is more than one philosophical school of phenomenology (Lopez & Willis (2004). Within nursing literature, the two most common approaches are descriptive phenomenology and interpretive (Hermeneutic) phenomenology. Distinct differences between the two are that in descriptive phenomenology researchers must bracket their personal knowledge and beliefs about the research phenomena, while seeking to describe the participants' experiences. Interpretive phenomenology suggests that researchers interpret the data collected in terms of their experiences and knowledge (Mapp 2008). Interestingly, four (Hoy et al 2007; Walsh & Kowanko 2002; Matiti & Trorey 2008; Hall & Hoy 2012) out of the five phenomenological studies utilised the interpretive approach to guide the studies.

Jacelon (2003) utilised a grounded theory approach to investigate the dignity of elderly patients in an acute care hospital. Similarly, Magee et al (2008) explored older people's experiences of using care services to discover how they feel that their dignity is maintained. Streubert and Carpenter (2011: 123) emphasize that theory generated from grounded theory study can help nurses better understand individuals' behaviour and emotions, especially in relation to dignity. Grounded theory tries to account for people's actions from the perspectives of those involved (Polit & Beck 2010: 269). This approach has become an important research method for nurse researchers and has contributed to several theories of phenomena relevant to nurses (Polit & Beck 2010: 269).

Case study approach is another very significant method of investigating a phenomenon of interest that is relevant to professional practice. Baillie (2009) utilised this method to explore patients and healthcare workers experiences to understand the meaning of dignity in an acute hospital environment. This approach allowed the researcher to explore participants' (nurses and patients)



experiences of dignity in one surgical ward. The researcher was able to obtain a wealth of descriptive information of the phenomena which permitted her the opportunity of learning about dignity from the perspectives of patients who were the recipient of care and from the perspectives of the staff who were the providers of care.

Two studies (Woolhead et al 2004; Bayer's et al 2005) do not document a specific research tradition guiding their research other than that they are qualitative studies. Polit and Beck (2014:276) suggest that some qualitative authors do not always document design decisions or describe the process by which such decisions were made. This, they say, make it very difficult to evaluate the published report. Nonetheless, other researchers believe, qualitative health research in general aims to answer 'what', 'how' or 'why' questions about social aspects of health, illness and health care, no matter if no specific research tradition is used (Green and Thorogood 2014: 33).

One study (Baillie et al 2009) used a survey research approach where questionnaires with both fixed and free text questions were the method of data collection. The authors were nurses representing the RCN in their sponsored survey, aimed at gaining an insight of its nursing members regarding the maintenance and promotion of dignity in clinical practice. These free text (open ended) questions were analysed using thematic analysis in relation to the effect of the physical environment and organisation on respondents' ability to deliver care, and care activities which respondents perceived could affect patients' dignity (Baillie et al 2009). One of the strengths of this method of data collection is that it provides the respondents with greater anonymity as there is no face-to-face interaction between the respondent and researcher. Nonetheless, the limitation of the questionnaire is that there is no opportunity to ask respondents to elaborate, expand, clarify or illustrate their answers (Parahoo 2014: 293).

The RCN has a large number of members within the UK, and geographically, it would have been impossible to do face-to-face interviews with all respondents

in these circumstances (Kumar 2014: 180). Through this method of data collection a considerably large number of healthcare practitioners who work with older people were able provide an insight of how dignity is promoted or compromised in care practice.

Other studies used data collection methods commonly associated with qualitative research approaches. These included focus groups, direct observations and face-to-face interview to explore older people and healthcare workers experiences of dignity. Three studies (Walsh and Kowanko 2002; Matiti & Trorey 2008; Hill and Hoy 2012) used unstructured interviews to collect data from patients and healthcare practitioners. In comparison, Webster and Bryan (2009) explored older people's views on dignity utilizing semi-structured interviews to gather data from ten older patients. In qualitative research, both of these data collection methods are regarded as the most in-depth approach to exploring a phenomenon of interest in greater detail and encourage the participants to share their experiences (Sorrell & Redmond 1995; Tod 2010). Several studies (Bayer et al 2005; Jacelon 2003; Hoy et al 2007; Woolhead et al 2004; Baillie 2008; Magee et al 2008) utilized triangulation of data sources, for example, participant and non-participant observations, focus group interviews with care providers and a combination of focus groups and interviews with the older participants. Data triangulation is a strategy frequently used to enhance the trustworthiness of the research findings (Roberts et al 2006) within some qualitative research tradition. Nevertheless, phenomenological researchers rely on a single method of data collection, primarily on in-depth interviews with individual participants (Polit & Beck 2010: 339).

Jacelon (2003) and Baillie (2009) combined participant observations and interviews as methods of data collection. Participant observation entails generating data by observing and participating in the daily life of a group or social setting and is particularly effective for studying everyday activities in context (Allen 2013: 353). Within non-participant observations the researcher does not get involved in the activities of the group, but remains a passive

observer, watching and listening to its activities and drawing conclusions from this (Kumar 2014: 174) as exemplified in Hoy et al's (2007) study.

All studies used varied sample sizes appropriately associated with qualitative methodology. In qualitative studies, there are no specific rules for sample size. There is no agreement among researchers as to the adequate numbers of participants required to fully explore a topic. Generally speaking, the researchers need to justify the sample size on the basis of achieving informational redundancy or theoretical saturation, balanced against the amount of information generated and the analytical task it poses (Kelly 2013: 317). This was evident in all studies assessed and reviewed.

Although not all of the qualitative studies described appropriate strategies to ensure rigor, data collection methods, research approach, and the findings which provided thick description of dignity from both older people and nurses' perspective ensured the rigor of these studies. A number of common themes of dignity and how it can be enhanced or compromised were identified in the findings of the studies reviewed.

## Appendix B: Articles selected for Review

**Appendix B: Table of included research studies**

Authors/Country/Title of study	Study aim	Sample & setting	Sampling & data collection	Theoretical framework and/or types of data analysis	Approaches to Rigor	Themes emerging
Walsh & Kowanko (2002), Australia <i>Nurses' &amp; patients' perceptions of dignity</i>	Uncover patients & nurses' perceptions of dignity based on the experiences of patients & nurses & identify nursing practices which maintain or compromise patient dignity	5 patients & 4 nurses. Ward of a large metropolitan hospital.	Volunteer sampling. Unstructured interviews.	<b><u>Interpretive phenomenology</u></b> Transcribed text was analyzed using interpretative hermeneutic approach, whereby themes emerging were explored	Data collection methods and analysis appropriate to the study approach. No mention of peer review or member checking. No mention of audit trail/reflexivity. However, thick descriptions of dignity provided.	<b>From nurses:</b> privacy of the body, giving control, the patient as a person, showing respect, advocacy and giving time. <b>From patients:</b> Being exposed, having time, being seen as a person, the body as object, being acknowledged, consideration
Jacelon (2003), USA <i>The dignity of elders in an acute care hospital</i>	Research question was: "what social processes do elders engage	5 patients aged 75 and over. 1 family member and	Purposive sampling. Interviews and participant	<b><u>Grounded theory</u></b> Transcribed text was analyzed using NUD*St software	Data triangulation. Prolonged engagement. Participation in	<b>Self-dignity:</b> as an attribute of dignity. Interpersonal dignity: as an attribute of dignity.

	in during hospitalization"	1 nurse Medical ward.	observations.		peer research group. Bracketing prior assumption. Rich description of findings.	<b>Privacy:</b> this was viewed as an interface between self-dignity and interpersonal dignity
Woolhead et al (2004), UK <i>Dignity in old age: what do older people in the UK think?</i>	Explore the concept of dignity from the older person's perspective.	72 older participants in 12 different settings	Purposive sampling 15 focus groups and 2 individual interviews	No mention of actual research design other than that is qualitative methods	Data triangulation. Rich description of findings. Researcher identify that negative cases were investigated closely.	Dignity of identity, human rights and autonomy.
Bayer et al (2005), Europe (6 European countries). <i>Dignity: The voice of older people</i>	Explore older people's views of what was meant by dignity and how it was experienced in	391 older people in 6 European countries. All aged over 60 years.	Purposive sampling. 89 focus groups and 18 individual interviews.	No mention of actual research design other than that it is qualitative methods.	Data triangulation. Rich description of findings.	Respect and recognition, participation and involvement, and dignity in care

	their day-to-day lives.						
Hoy et al (2007), Denmark. <i>The elderly patient's dignity. The core value of health</i>	Explore the meaning of being an elderly patient as experienced by care providers in geriatric and medical hospital units.	29 nurses and healthcare assistants who worked on medical and geriatric wards	Non-participant observation and interviews	Data analysis inspired by Ricoeur's <b><u>Hermeneutics phenomenology</u></b>	Data triangulation. Rich description of findings.	Dignity of identity, dignity as autonomy and dignity as worthiness	
Leslie Baillie (2009), UK. <i>Patient dignity in an acute hospital setting</i>	To investigate in an acute hospital setting: The meaning of patient dignity. How patients' dignity is threatened. How patients' dignity is promoted.	24 patients aged 34-92 years and 26 registered nurses and support workers.  22 bedded surgical ward in an acute hospital in England.	Purposive sampling.  Unstructured interviews and participant observations	<b><u>Case Study</u></b> Data analyzed manually using the Framework approach which entailed combining themes from the theoretical framework with themes from the data.	A research diary with reflective notes and an audit trail was maintained by the researcher.  Data triangulation. Prolonged engagement. Pilot of data collection methods which were critically reviewed by the	Self-respect, feeling valued, Being dressed appropriately,  Not having their bodies exposed  How staff behavior affects dignity.	

						researcher's supervisors. Rich description of findings.	
<p>Magee et al (2008), UK. <i>Measuring dignity in care for older people: A research report for Help the Aged</i></p>	<p>To explore the views of older people and cares regarding the Help the Aged dignity domains and the measurement of dignity in care.</p>	<p>Five focus groups were recruited with the aid of Age Concern in East London, a care home and a cares' center in Oxfordshire, and a day center for elderly Asian people in west London. One interview was also conducted with a male care home resident who was unable to attend a</p>	<p>Purposive sampling. Care home residents : 4 female, 1 male  Asian home care service users: 3 female, 3 male  Home care service users: 8 female, 1 male  At home after recent hospital discharge: 2 female, 2 male+ 1 male interview</p>	<p><b><u>Grounded theory approach.</u></b>  Data analysis using framework analysis (Ritchie and Spencer 1994 ).</p>		<p>Data collection triangulation. Rich description of findings.</p>	<p>Four cross-cutting themes were identified: <b><u>Choice:</u></b> Support to make choices and personalization and tailoring of care <b><u>Control:</u></b> Respect for individual lifestyle and preferences and involvement in decision making. <b><u>Staff attitudes:</u></b> Respectful attitudes in relation to all aspects of care and curtesy and sensitivity in all forms of communication. <b><u>Facilities:</u></b> Availability of and access to appropriate facilities/equipment</p>

		focus group discussion.	Cares: 5 female, 5 male.  Total number of participants: 35			
Matiti & Trorey (2008), UK. Patients' expectations of the maintenance of their dignity	Explore patients' expectations regarding the factors that contribute to the maintenance of their dignity while in hospital.	102 patients in 3 hospitals in the UK. 53 males and 49 females.	Convenience sampling.  Semi-structured interviews.	<b>Phenomenological hermeneutic</b> approach.  Content analysis of transcribed interviews to identify the main themes perceived to be affecting dignity.	Prolonged engagement- interviews lasted 20-25 minutes. Rich description of findings.  No other strategies mention in the report.	<b>Six prominent themes:</b> Privacy, confidentiality, communication and the need for information, choice, control and involvement in care, respect
Baillie et al (2009), UK. <i>Nurses views on dignity in care</i> <b>An RCN survey</b>	To gain the perspectives of the nursing workforce regarding dignified care in practice.	1,110 nurses and health care support workers who worked with older people	Survey of RCN members: a survey link was emailed to RCN members.	Quantitative data analyzed using Excel package to calculate percentage. This paper only	This was a quantitative study. Questionnaire piloted and refined according to	Some respondents reported that certain working environments either promoted or compromised patient dignity, such as single rooms or two-bed bays,



	To understand the challenges nurses experience in care deliver.		Closed, fixed response questions elicited demographic information. The free text questions asked respondents what helped or hindered dignified care in relation to environment, and organisation, and what care activities could potentially threaten dignity.	reported the qualitative data and this data was analyzed using thematic analysis	feedback. Poor response rate. From 70,000 members to whom the questionnaire was link emailed only 2048 of them completed. However, of these over 1000 worked with older people. Rich description of findings.	were seen to promote privacy. Other environments such as mixed-sex wards/bays and physical space where curtains were used around bed areas were seen to compromise dignity. NHS targets, unsupportive management and budgetary pressures were barriers to dignified care.
Webster & Bryan (2009), UK. <i>Older people's views of dignity and how it can be promoted in a hospital environment</i>	To investigate the lived experiences of older patients in hospital, to explore their views on dignity and the	10 older patients aged between 73-85 years. Patients were	Purposive sampling.  Semi-structured interviews.	<b><u>Descriptive phenomenology.</u></b>  Colaizzi's (1978) framework for data analysis was applied.	One researcher directly worked with patients in the clinical. Researcher documented any potential biases.	The following factors had the potential to promote dignity;  Privacy for the body, cleanliness, independence and being able to exert

	factors which promote dignity.	interviewed in their own homes, following their discharge home from unplanned hospital admission.		Data were transcribed verbatim by the researcher and analyzed for themes.	Final stage of data analysis- member checking omitted. Instead the transcriptions and coding reviewed by an independent experienced colleague to check coding and to identify any omissions. Rich description of findings.	control, sufficient time from staff, attitudes to older people and communication.
Hall & Hoy (2012), Denmark. <i>Re-establishing dignity: nurses' experiences of caring for older hospital patients</i>	Explore clinical nurses' experiences of caring for older patients. The research question addressed how do nurses experience caring for older patients in hospital.	22 registered nurses and seven nursing assistants (n=29)	Purposive sampling Unstructured interviews. One author interviewed 2 and 2 together to stimulate group dynamics	Van Manen's <b><u>hermeneutic-phenomenological</u></b> approach for data analysis. Interviews were transcribed verbatim.	Data collection triangulation. Prolonged engagement. Rich description of findings.	Nurses' experiences of caring for older patients in hospital were seen as helping the older patients to regain dignity. Dignity was a value related to: Respect, integrity, worthiness.

**Appendix C: Letters from the Trust regarding Consent to use site**

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## **Appendix D: Ethical Process**

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Content removed on data protection grounds





## **Certificate of Employers' Liability Insurance(a)**

Content removed on data protection grounds



Coventry University  
Priory Street  
Coventry  
CV1 5FB

158 Edmund Street  
Birmingham  
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t: 0121 253 3100  
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August 2012

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**Coventry University**  
 Priory Street  
 Coventry CV1 5FB  
 Telephone 024 7688 7688

**Professor Ian M Marshall**  
 Pro-Vice-Chancellor (Research)



**TO WHOM IT MAY CONCERN**

RRU/Ethics/Sponsorlet

26 October 2012

Dear Sir/Madam

**Researcher's name:** Bhupinder Pawar

**Project Title:** Dignity of older patients in emergency care: nurses experiences

The above named researcher has successfully completed the Coventry University Ethical Approval process for her project to proceed (ref: 7298).

I should like to confirm that Coventry University is happy to act as the sole sponsor for this researcher and attach details of our Public Liability Insurance documentation.

With kind regards

Yours faithfully

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**Pro-Vice-Chancellor's Office**  
 Direct Line 024 7679 5293  
 Fax 024 7688 8030  
[www.coventry.ac.uk](http://www.coventry.ac.uk)



## Appendix E: Consent Form & Participant Information Letter

### CONSENT FORM (version 1 22/01/13)

**Title of Project:** Dignity of older patients in emergency department: ED nurses experiences

**Name of Researcher:** Bhupinder (Bobby) Pawar

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw from the study at any time without giving my reasons.
3. I understand that the research findings may be disseminated in journals and presented at conferences and that I will not be identified.
4. I agree to take part in the above study.

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Researcher

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

When completed: Copy to participant and one for researcher site file

## **PARTICIPANT INFORMATION SHEET** (version 1, 22/01/13)

### **Title of study: Dignity of older patients in emergency department: experiences of ED nurses**

I am inviting you to take part in a research study but before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and ask me if there is anything unclear or if you would like more information.

- Part 1 tells you the purpose of this study and what your participation will involve
- Part 2 gives you more detailed information about the study.

#### **Part 1**

The purpose of this study is to explore ED nurses experiences of providing care to older patients in relation to dignity. The last decade has seen overabundance of policy documents concerning the dignity of older patients in health and social care. Key documents such as The Dignity in Care and the NMC Guidance for the Care of Older people were launched with the aim of eliminating tolerance of dignity in health and social services through raising awareness and inspiring people to take action. Emergency departments are seen as the 'front doors' through which many older patients start their health care journeys. Yet the last decade has also seen emergency departments undergo major reforms and thus nursing care being more focused on meeting targets, instead of meeting the needs of older patients. Therefore, I am interested to explore your experiences of caring older patients to discover what your understanding of dignity is, and how it is promoted or compromised in a busy ED.

I am inviting you to participate in this study because you have first-hand experience of providing care to the older patients in ED.

It is up to you to decide whether or not to take part. If you chose to participate you will be given this information sheet to keep and be asked to sign a consent form. You would be free to withdraw from the study at any time without giving a reason.

#### **Part 2**

If you chose to accept my invitation you will be asked to participate in a face-to-face interview. This interview will take place in a quiet area of ED or an area/place of your own choosing. The interview will last approximately 1 – 1½ hours. The interview will be audio-taped and transcribed (written out in full). You will be asked if you would like to review the written copy (add, delete or comment on the content).

The interview will be analysed and a summary report of the findings will be offered to you if you wish to receive one.

In order to make interview arrangements I will need either an email address or phone number, and if you wish to receive a summary report at the end of the study I will need your postal address. These contact details will only be used for the purposes stated. Your name will not be used in the transcript or any future publications, and any information you give during the interview will be kept confidential. Only the researcher will have access to the interview tapes and transcripts, and all this information will be stored in a secure filing cabinet in the university office and on computer files stored on password protected computers. If you should choose to withdraw from the study none of the information you have given me will be used in the study.

As a study participant you will not receive any payment but if you incur any expenses (e.g. parking or transportation) as a result of your involvement in the interview I will reimburse you.

I do not consider that there are any risks involved should you decided to be involved nor are there any obvious benefits. This study has been approved by the Research Ethics Committee at Coventry University. However, if after participating you have any concerns about the way you were dealt with during the study or any possible harm you might experience, you are encouraged to contact the researcher directly (contact details below) or if you prefer to

Contact the Coventry University Ethics Committee Chair, Professor Ian Marshall, in writing to AB122, Coventry University, Priory Street, Coventry CV1 5FB, or by telephone 024 7688 5293.

Researchers' contact details: Content removed on data protection grounds

If you chose to be involved you will be given a copy of this information sheet and a signed consent form to keep.

*Thank you for your interest in this study. Your participation would be greatly appreciated.*

Date:

## Appendix F: Interview Guide

### Interview guide

**Research study:** investigation of ED nurses experiences of caring for older people to understand and describe their perceptions of dignity in the ED context.

Time of interview: \_\_\_\_\_ Date: \_\_\_\_\_ Place of interview: \_\_\_\_\_

Participant: \_\_\_\_\_ Interviewer: \_\_\_\_\_

### Interview procedures

#### **Phase 1: introductions, consent, demographics (experience & role)**

The purpose of this study is to explore ED nurses experiences of providing care to older patients in relations to dignity. I am interested in exploring your experiences of caring for older patients to discover what your understanding of dignity is, and the factors that can enhance or hinder dignity in ED.

During this interview you will be asked mainly three open-ended questions about your experiences of caring for older people in ED. I would like you to describe your experiences. The interview will be tape recorded and the recordings will be transcribed verbatim. Your name and other details will be anonymised to maintain your confidentiality.

#### **Informed Consent**

Have you read the information sheet relating to the study that was provided?

Have you signed the consent form to signal your willingness to take part in the study/interview?

Do you give your consent for the interview to be recorded?

Do you have any questions or concerns regarding the study and your participation?

#### Experience in ED

How many years have you worked in ED?



What is your position in ED?

### My role as a researcher

While you know I have worked in ED as LP for over 10 years, at present I am undertaking a professional doctorate degree at Coventry University. This study is being conducted for the purpose of this degree. I am here as a researcher with the aim of interviewing you to gather data (your experiences) for the study.

## **Phase 2**

Introducing the first question	Topic guides
Opening question	<p><b>From your experiences of caring for older people in ED every day, tell me what does dignity means to you?</b></p> <p>Use participant's own expressed experiences to further explore this experience.</p> <p>Further explore the participants experience following their expressed thoughts, experience etc.</p> <p><b>Use prompts/probes as required:</b></p> <p>How does this feel?</p> <p>What was important to you?</p> <p>What do you mean?</p> <p>Can you explain this in more detail?</p> <p>Give participants time to reflect/think</p> <p>Listen actively with positive body language.</p> <p>Encourage conversation relating to the purpose of the study.</p>

	Is there anything else you would like to say about the dignity of older patients in ED?
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### Phase 3

<p><b>Introduce other questions relating to factors that can impact on delivering dignified care in ED.</b></p>	<p><b>From your ever day experience of caring for older people, what factors enhance dignity in ED?</b></p> <p>Explore further according to the participants answers.</p> <p>Do you think dignity is maintained in ED?</p> <p>How do you promote dignity?</p> <p>What care practices promote dignity?</p> <p><b><u>Use probes/prompts as required:</u></b></p> <p>How did you feel?</p> <p>Was this important to you?</p> <p><b>From your experiences of caring for older people in ED, what factors can compromise/hinder dignity in ED?</b></p> <p>Explore further according to the participants answers.</p> <p><b><u>Use prompts/probes as required:</u></b></p> <p>How does this make you feel?</p> <p>What do you do in this situation?</p>
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**Phase 4: Bringing the interview to a close**

I have covered the questions I wanted to ask. Is there anything else you would like to tell me?

**Closing the interview**

Thank you for participating in this study. I really appreciate your time to do this. Many thanks for sharing your experiences with me.

**Turn off the tape recorder**

As I said earlier, the interview will be typed in full. Would you like to read your transcription?

## Appendix G: Data Analysis & Mind Maps

### Example of data analysis: Emerging themes?

#### Dignity compromised in ED?

Not having the time to provide nursing care	Work pressures and maintaining targets	Nursing patients in corridor compromises dignity	Not being able to maintain nutritional needs	Patients with dementia	Departmental constraints such specific areas
I have not got time to do this	When you have lots of patients in ED it impacts on giving dignified care	Nursing patients in corridor Care is compromised in corridor	Patient was vegetarian we only had no cheese sandwiches	Toileting dementia patients	Only problem in resuscitation room is curtains
I have 7 patients to look after	We should have patients in and out of A&E within 4 hours-very often patient dignity is denied because the patient is coming up to what we call the breach time so the patient may be wet so we	There was no room to put patients in	They may have been in A&E for 4 hours we have not given them anything to eat-they are not getting adequate food or drink	Dementia patients take their clothes off, wander around	People wondering in and out of resuscitation room
Dignity is maintained depends on who is working		We are under a lot of pressure-patients waiting in corridor		Biggest compromise is dementia patients	Relatives can hear what is going on in resuscitation room
It's basic care that should be being		Patients in corridor everyday One night I found a	We are very limited on what meals that we can	Dementia patients are the most difficult to manage	Resuscitation room is worse for patient dignity
				Dementia is associated with elderly patients	In resuscitation room

<p>given to patients and it should be 24/7</p> <p>It's their basic human rights they are being denied</p> <p>Nursing is about compassion enhancing dignity and it's not being met</p>	<p>are being told by managers to move the patient out of the department so they are going to wards in wet beds.</p> <p>They have got pressure areas that have not been seen to, there are infection control measures that are not in place prior to them going round to the ward</p> <p>They have got pressure areas that have not been seen to, there are infection control measures that are not in place prior to them going round to the ward</p> <p>I think the</p>	<p>very ill patient in corridor</p> <p>When we are in corridor patient's dignity cannot be met</p> <p>It is impossible to maintain privacy in corridor</p> <p>It is embracing for them when they are being sick in the corridor</p> <p>Everyone knows you can't maintain dignity in corridor</p> <p>I wouldn't want my mum in corridor</p> <p>The corridor patients and resuscitation area-hard for dignity</p>	<p>deliver and we are very limited on sandwiches and most of them don't have teeth so they can't chew</p>	<p>and the fact that they get up and walk around and disturb other patients</p> <p>Just a huge stigma attached to dementia</p> <p>Everybody rolls their eyes-they get very frustrated</p> <p>Often dementia patients require a one on one nursing which you can't provide in an acute</p> <p>Dementia patients when they are lying in their beds and taking off their sheets I think it's terrible when you are short staffed</p>	<p>they are uncovered</p> <p>Dignity is not always met in resuscitation room</p> <p>It is annoying when people just walk in when we are changing patient</p> <p>I feel irritated about dignity in corridor/resuscitation room</p> <p>Relatives can hear everything in resuscitation room</p> <p>Resuscitation area is poor for dignity due to curtains-you can hear everything</p> <p>Yes in the corridor and resuscitation area can impact on</p>
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	<p>constraints of the department means that privacy and dignity isn't maintained and they are very much on a conveyor belt type system where they are put into a cubicle for the shortest amount of time and they are moved in and out and their dignity isn't maintained all the way through their journey</p> <p>There just not the staffing level all the time so they are quite often left on the trolley-they don't know to press the call bell when they need to they are quite often incontinent</p>	<p>Everyone knows you cannot maintain dignity/privacy in corridor</p> <p>There is no dignity or privacy on the corridor</p> <p>In the corridor you are mainly head to foot with trollies-often we have up to 20 patients in the corridor</p> <p>There is no screening in the corridor no rooms to put anybody into, everyone can hear what's happening to everybody else</p> <p>There is no screening in the</p>	<p>they are left lying in the corridor in wet beds-it should not happen</p> <p>When you have severely dementia patients you know it is hard work there's no staff</p> <p>It's the corridor that's the main concern-when we get dementia patients that are exposed and their isn't enough staff to properly look after them</p>	<p>older patients dignity</p> <p>People just walk in through the curtains they don't knock</p> <p>Resuscitation area that's probably one of the worst for dignity because the curtains are poorly fitted-notes are left lying around-when you are handing over to a ward or discussing their care its overheard by everyone</p> <p>Resuscitation area-I don't think there is dignity in there because we have very exposed patients.</p>
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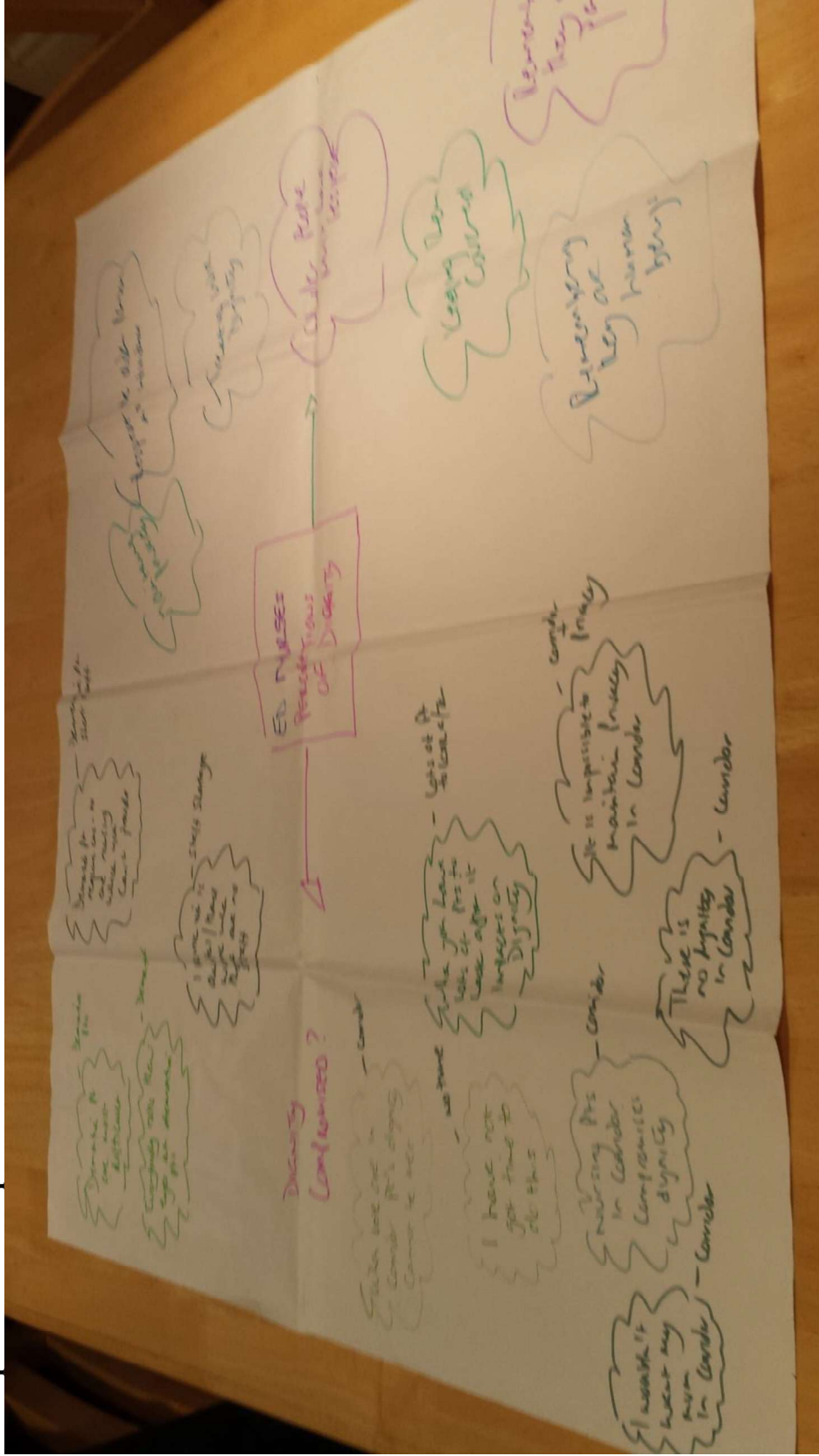
	<p>dehydrated-</p> <p>There just not the staffing level all the time so they are quite often left on the trolley-they don't know to press the call bell when they need to they are quite often incontinent dehydrated-</p> <p>I think staffing levels time restraints and</p>	<p>corridor no rooms to put anybody into, everyone can hear what's happening to everybody else</p> <p>There are no toilet facilities in the corridor-older people often need the toilet more than younger people</p> <p>It's very difficult sometimes to provide dignity that's needed for somebody to go to the toilet</p> <p>I feel really bad you know it's something that you wouldn't want somebody not to be able to go to the toilet.</p>			<p>There are no single cubicles – its open 6 beds where patients, relatives etc are walking through</p> <p>There is no dignity in resuscitation area at all</p> <p>You can hear absolutely everything-there is no dignity on somebody who has just been diagnosed with terminal cancer or you know being told that they are not going to make it</p> <p>Other relatives next door could be listening to this whole conversation-I don't think there dignity for each of the patients in</p>
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			<p>If you are in the corridor you've got no privacy- anything you say are saying can be heard by anybody else</p> <p>There is no privacy into the fact that you have not got any curtains or screens or a door or anything for you know if you are on the toilet or have toiletry needs there is no privacy at all</p> <p>They shouldn't be sitting in a corridor where everyone can hear their observations being taken and there's no confidentiality or dignity being</p>			resuscitation
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		<div>nurses in a corridor</div> <div>I don't think there is any dignity in that there are members of public walking past</div>				
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Example of Mind Map



## **Appendix H Reflexivity & Insider Research**

### **Introduction**

The aim of this section is to explore from a personal perspective issues and challenges associated with conducting a phenomenological research with my peers and colleagues. The issues with conducting 'insider research,' included recruitment and interviewing processes, particularly in relation to ethical implications (McDermid et al 2014) which are explored through 'reflexivity'. Moreover, reflexivity is also regarded as a method of achieving a phenomenological reduction (bracketing) and was fundamental in this phenomenological research.

### **Reflexivity**

Reflexivity is the continuous process of reflection by researchers on their values, preconceptions, behaviour or presence and those of the participants that may affect the interpretation of responses (Parahoo 2014: 253). In qualitative research, reflexivity is a process that helps researchers to consider their position and influence during the study (Savin –Baden & Major 2014: 81). Qualitative research involves human subjects and this raises inevitable questions about the impact of the researcher's own values and beliefs on their choice of research subjects, engagement with and conduct of the research (Lee 2009: 62). Jootun et al (2009) suggests that researcher reflexivity is crucial in nursing research where the researcher often knows the participants. The process of reflexivity allowed me to be open, honest and insightful about how my role of 'insider' researcher impacted the study. Indeed, Lee (2009: 65) believes reflexivity during a research project allows the researcher to reflect upon the limitations of the research and decisions about methodology or ethics or analysis.

While there are no specific guidelines for when or how reflexivity should take place, number of authors recommend memo-taking, writing short notes or

keeping a research journal during the research study as a way of maintaining researcher reflexivity (Lambert et al 2010; Bonner & Tolhurst 2002; Jootun et al 2009; Lee 2009). Therefore, I kept a reflective journal of my thoughts, feelings, decisions, actions and reflections on my research project as it unfolded (Lee 2009:64)

### **Insider Research**

This research study is conducted in the ED where I work as a nurse. This is regarded as insider research because as a researcher I chose to conduct the study with a group of nurses with whom I work and have common experiences. While there are a variety of definitions of insider-researcher, generally 'insider' researchers are those who choose to study a group to which they belong (Unluer 2012). In qualitative studies it is increasingly common for researchers to be part of the social group they intend to study (Bonner & Tolhurst 2002). As qualitative research focuses on human participants and their experiences, researchers need to confront directly the issues of relationships with the participants (Lee 2009:62).

Coghlan & Casey (2001) suggest that nurses who undertake a research project in and on their own hospital normally do so because they want to improve aspects of nursing care practice, education and management and intend to remain within their desired career path when the research is completed. In undertaking the professional doctorate degree, I was combining an academic and research focus within my practice (Lee 2009: 51). Like most doctoral students, I enrolled on the programme as a novice researcher with a research interest that stemmed from reading and reflecting on literature relating to a topic that interested me and could impact my area of practice (West et al 2012). Conducting research with people you know and work with is associated with a number of benefits. In particular, gaining access to the site and recruitment of potential participants are some of the benefits of 'insider' research. Other benefit to being a member of a group one is studying according to Dwyer &

Buckle (2009) is acceptance. They highlight that being a part of a group being studied provides a level of trust and openness with the participants that would not have been possible otherwise. Participants might be more willing to share their experiences because there is an assumption of understanding and an assumption of shared distinctiveness and thus, richness of the data collected. While this shared status can be very beneficial, it also raises a number of specific issues that has the potential to impede the research process as it progresses (Dwyer & Buckle 2009). In most cases the issues that can impede on the insider research are listed as the antitheses of the benefits (West et al 2012) such as peers and colleagues feeling pressured, and believing they have no choice but to take part in the research. Moreover, being an insider researcher raises the issues of undue influence of the researcher's perspective on the study process (Dwyer & Buckle 2009). This can further lead to researcher bias where personal or professional beliefs may unfairly influence or prejudice the research (Lambert et al 2010). Nonetheless, reflexivity allows the process of objectivity to flow through the research with the aim of reducing bias (Lambert et al 2010).

### **The Context of the Study from Professional and Personal Perspectives**

The decision to undertake a research study exploring ED nurses perceptions and experiences of older people's dignity was certainly related to a number of issues. This included some personal reflections and current issues relating to the care of older people and personal experiences.

My interest in the dignity of older people began several years ago, prior to embarking on the professional doctorate degree programme. A number of policy documents and strategies concerning the dignity of older people in health and social care were produced by the government during the first decade of year 2000. The National Service Framework (NSF) for older people was one of them (DoH 2001a) and this was followed by other documents such as Essence of Care (DoH 2001b). As a nurse I observed that more and more elderly patients with complex needs were attending ED. It was evident that with an

aging population, older people required urgent nursing care and as a nurse I had a moral and a professional obligation to ensure that these patients were treated appropriately and their dignity maintained. My curiosity was slowly being fuelled by the events associated with the care of older people.

Dignified care of older people became a major concern politically and within professional bodies and organisations such as Nursing and Midwifery Council (NMC) and the Royal College of Nursing (RCN). A number of high profile campaigns and research studies emphasised the importance of dignified care. Empirical studies explored older people and nurses views of dignity in a number of healthcare settings. Reading these reports made me reflect on my practice in ED. What did dignity of older people mean to my colleagues? What was their perception of dignity? Most of all did they think dignity was maintained in ED? Dignity is relevant to all human beings and nurses are at the vanguard of providing nursing care in all care settings. As a professional nurse having worked in a number of busy EDs, I not only had experience of caring for older people, but also experiences of working with, and observing, other nurses' delivering care. The more I thought about this the more I wanted to explore this phenomenon from the perspectives of ED nurses.

A number of high profile reports relating to older people's dignity further added to my interest in exploring the concept of dignity from my area of practice.

*Hungary, thirsty and unwashed*, was a headline on the front page of The Independent newspaper where the findings of recent investigations in the care of older people in the NHS were reported (15 February 2011). Another report, the Francis report of the inquiry into Mid Staffordshire NHS Trust also contributed. While these reports did not relate to emergency care, they fostered my interest in the concept of dignity. Embarking on a professional doctorate degree programme was an opportunity to engage in a practiced based issue that will generate knowledge for practice.

To achieve the aims of the study I adopted a descriptive phenomenological approach. I wanted to gain in-depth descriptions of ED nurses experiences of caring for older patients in their natural ED environment. An important component of descriptive phenomenology is that researchers must 'bracket' their own beliefs and experiences of the phenomenon under study to understand in order to focus on understanding lived experiences from the perspectives of the participants. I came into this researcher role as a nurse and a lecturer with several years of nursing experiences and personal experiences of the phenomenon under study. Whilst I recognised that the examination of ED nurses experiences of dignity would be best addressed using the descriptive phenomenological approach, the notion of putting aside personal experiences and professional knowledge of dignity was challenging but achievable primarily by keeping a research journal. The following excerpt from my journal demonstrates the reflective process that occurred:

*"I have worked as a lecturer practitioner for over 10 years. On the occasions when I had the opportunity to work clinically in ED I have cared for a number of older patients. Will I be thinking about these experiences during data collection? Or will I be so engrossed in the nurses' stories that I will be living their experiences as being told by them?"*

*I have done extensive reading relating to dignity. Will this reading have any impact on data collection or data analysis? When I think about this reading, my professional experience and knowledge it worries that I may not be able to describe what they have experienced as an honest account.*

*But then I am also thinking about why I want to do this study. The concept of dignity interests me. It is an important issue within nursing. It is important to all patients who receive care, especially older people. I want to know what other ED nurses' perceptions of dignity are. When they are going about nursing patients in ED do they think about dignity? My study will give them an opportunity to reflect on their experiences and*

*reveal what dignity means to them and how they perceive dignity is promoted or compromised in emergency care. The study will give them the voice to share their everyday experiences. From which a description of dignity may emerge. The findings will be valuable for ED nurses, patient care and teaching... Nursing practice could also be enhanced by utilising the findings in-house education of ED nurses”.*

(Research Journal 7<sup>th</sup> March 2010)

### **Choosing to Conduct the Study in My Workplace**

The location where research takes place must be suitable for locating and recruiting participants with the knowledge of phenomenon under investigation. Some authors argue that for this to take place the researcher has to know the setting intimately because it is an integral place where knowledge may be uncovered (Holloway & Wheeler 2010: 47; Savin-Baden & Major 2014: 307). As mentioned earlier I wanted to investigate the phenomenon of dignity from ED nurses perspective and so, very early on during the programme, I considered my own workplace as one of the suitable sites in which to conduct my study. For me this was where the knowledge of the concept of dignity could be located. However, there are conflicting views on carrying out research in one's own setting because it can be complex and difficult (Holloway & Wheeler 2010: 65) due to the intimate relationship between the participant and the researcher (Holloway & Wheeler 2010: 65). In contrast, Dwyer and Buckle (2009) suggest conducting research in your workplace does not influence the research process in a negative way as any potential biases and perspectives can be reduced through reflection. They believe that the costs and benefits must be carefully weighed. Therefore, I carefully considered this and wrote a number of questions in my journal to consider and discuss with my director of studies during the first year of my studies:

*Study site?*

- *In ED?*
- *Local ED?*



- *Why other EDs?*
- *Practical reasons?*
- *Can research be conducted in your workplace?*
- *Discuss with MG at next meeting*

(Research Journal 20<sup>th</sup> January 2010)

In choosing to conduct a study in the researcher's practice organisation is advantageous because the researcher is already immersed in the practice context and have built up knowledge of the processes and the potential participants (Coghlan & Casey 2001). Having worked in this ED for a number of years I knew that the department admitted and treated a large percentage of older people with complex needs and all nurses working in the ED had the experiences of caring for this group of patients. As a result, I was confident that as a researcher, engaging with ED nurses would allow the level of engagement to provide an in-depth understanding of the concept of dignity. In addition having worked in the ED and the Trust, access to conduct the study would not pose any difficulties as the ED manager and other senior members knew my role as a lecturer and practitioner and the nature of the doctorate degree I was doing.

Moreover, being a part of the ED, I was already immersed in the routines and regulations of the department and had a built up knowledge and understanding of the nursing team. I was also a respected member of this nursing team. This pre-existing relationship with the nurses would be valuable in building a rapidly accelerated rapport during data collection (McConnell-Henry et al 2009/10). A number of local EDs were also considered as possible sites to conduct the study, but I felt that negotiating access to appropriate clinical nurse gatekeepers may prove difficult as support would be required from other stakeholders (Holloway & Wheeler 2010: 47), such as the chief executive and director of nursing of the local Trust. Powerful gatekeepers can often refuse access for a

variety of reason such as suspicion and fear of criticism or the sensitive issues being investigated (Holloway & Wheeler 2010: 47).

Despite this, even if access to conduct the study was feasible in other EDs, organising intermittent visits, locating participants who were willing to take part in the research and places to interview participants would have been difficult and challenging. Not being familiar with the shift patterns, not understanding the dynamics of an unfamiliar ED and not having the time to become familiar with the participants were other factors that impacted the site selection decisions. Consequently, these potential obstacles had some degree of influence on the selection of my own workplace for the study (Hewitt-Taylor 2002). Indeed, Savin-Baden and Major (2014: 313) believe that site selection should not be entirely based upon sites to which an access point is readily available, but it should certainly be a consideration when undertaking the site and participant selection process.

In this case it was clear that the nurses I worked with in the ED would be able to provide personal accounts of their experiences of the concept of dignity. Equally, it can be argued that nurses in other EDs also had similar experiences and could be potential participants for the study. At this stage of the study process, I faced a number of practical issues. As Flick (2014: 164) acknowledges, researchers frequently face problems of negotiating proximity and distance in relation to their study. As a researcher it is necessary to make the decision between adopting the perspective of either an 'insider' or an 'outsider' with regard to the focus of the research (Flick 2014: 164). In this study it was obvious that I was leaning more towards the 'insider' perspective. Nevertheless, caution is voiced by a number of researchers in carrying out research in one's own setting due to issues of power and risk to the researcher and the participants (Creswell 2007: 122; Holloway & Wheeler 2010: 65). These are discussed in detail later in the chapter.

The question that I did ask myself was that could this study be conducted in my place of work? Could the potential risks be minimised? Following in-depth discussion with my director of studies and exploring the literature on 'insider' research, the conclusion was yes that it could be done as long as I understood the significant potential challenges associated with 'insider' research. These challenges included issues of pre-understanding of the research topic and context, ethical issues relating to disparities in power, recruitment and interviewing (Coghlan & Casey 2001; McDermid et al 2014).

### **Pre-understanding**

As a nurse working in the same ED, I had a pre-understanding of the ED and its function. This included the shifts, routines and regulations of the department. I also worked with all the nurses and informally knew how long they had been employed in the department. What's more I understood the ED culture and the everyday language used by the nurses (Burns et al 2012). Having pre-understanding was beneficial in gaining access to conduct the study and in participant recruitment. As expected being an 'insider' researcher I had the knowledge that an outsider researcher would not be privy to. I was accepted by the participants whilst an outsider researcher may not have been so easily accepted. As an ED nurse I could relate to the experiences they were discussing. I could understand the areas of the ED being described. I knew what they meant when they talked about a specific area such as 'minors' or 'majors'. Coghlan and Casey (2001) further explain that a researcher who has previous knowledge, insight and experience of the setting can use the internal jargon and draw on their experience to follow up during the interview in order to obtain richer data. For example, the following extract from an interview illustrates how my pre-understanding of the study site and participants was valuable:

*B: "From your experience of caring for older patients can you describe an experience where you felt that older patient's dignity was compromised?"*

*Participant: "Yes well since we started nursing patients in the corridor, I feel that care is compromised....."*

*Participant: "Resus is the worse place for maintaining dignity..."*

(Interview 1)

In this interview a participant is describing areas where patients are cared for in the department. For example, when this participant is talking about 'resus', I know this is the resuscitation area of the ED where care is provided for patients who are critically ill or injured. Similarly, the corridor described in this extract is an area which is often utilised when all areas of ED are full and no cubicles are available for patients to go into on arrival in the ED. I can further relate to what it is like to be working in those specific areas. Having this insider knowledge and understanding of the ED culture and the language was valuable, especially in affecting the flow of the interactions during the interviews. While an outsider who may be unfamiliar with the language and culture would have had difficulties understanding the true meanings (Jootun et al 2009). Continued interruptions for clarifications of language, meaning and specific ED areas by an 'outsider' researcher could frustrate the participants.

Inevitably, having a pre-understanding of the ED and the nurses did have a number of disadvantages. For me these related to issues of being very familiar with the ED culture and knowing the participants. This familiarity, according to Oliver (2010) as cited in West et al (2012) can cause researchers to overlook aspects that the more removed outsider might notice. I did not want this familiarity to cause me to take aspects of the study and the intricacies of the participant narratives for granted or as given as important data could be lost to the study. Coghlan and Casey (2001) suggest that when the researcher conducts interviews with participants known to them, they may assume too much and so not probe as much as if they were outsiders or ignorant of the situation. Even though this was a potential threat, in reality I found I was able to ask for clarity as and when required as illustrated in the following interview extract:

*Participant: "they (older patients) have got to have respect and you know just that we are medically trained it doesn't mean they haven't got the knowledge to say yes or no....."*

*B: "Tell me a bit more about respect...what do you mean by respect?"*

*Participant: "By respecting their culture....respecting whether they want the treatment or not.....yes respecting the patient as an individual....."*

(Interview 2)

Despite this, I wanted the participants to describe their experiences in as much detail as possible. I did not want them to assume just because I had experience of working in ED I already knew what they were going to tell me. As Hewitt-Taylor (2002) highlights there is always the potential that the study participants would assume that the knowledgeable researcher might consider their experiences mundane and therefore not sufficiently significant to report when these might, in fact, be important data elements. In an attempt to overcome these potential issues I adopted two strategies: First I encouraged participants to fully describe all experiences as they thought were memorable, illustrative or important. Secondly, I framed the first question by introducing my pre-existing knowledge and understanding of ED. For example:

*"As you know I have worked in ED for many years. However, I want you to describe your experiences. From your personal experience of caring for older people in ED what does the dignity of older people means to you?"*

McConnell-Henry et al (2009/10) believe that framing the question with pre-existing knowledge serves two purposes. Firstly, the researcher acknowledges the participant's presuppositions. Secondly, by contextualizing the question the risk of the participant leaving something out of the story in the belief that the researcher already knows that information is diminished. Dealing with the researcher's pre-existing knowledge when interviewing someone known to the researcher may be problematic because the participant has consented to the use of information obtained, only during the particular interview (McConnell-

Henry et al 2009/10). I knew this was another potential issue for me. Therefore, during recruitment, potential participants were informed that only information gained through the interview interaction would be used for the study and any other information relating to them that I was aware of from a professional relationship, was strictly confidential and will not be part of the study. This was re-iterated again to each participant at the start of data collection. Other strategies used to minimise the effect of this pre-understanding included collecting data when I was not on duty in ED and therefore not in a uniform. Data was also collected away from the ED at a place chosen by the participants. I wanted the participants to accept me as a researcher so that they had no doubts that only information they consented to would be included in the data analysis and findings. Lastly, after each interview I reflected on the interview process by writing personal memos in my reflective journal. The following extract describes what I felt after an interview:

*The interview today was with a participant who is a band 5 and has been in ED for about 2 years. I wanted her to accept me as a researcher. I wanted her to describe her experiences of dignity in detail as possible. Again as with all the nurses I did not want her to think that as I have so many years of ED nursing experience that I would already know what she was going to tell me. That's why when I started the interview I emphasised that even though I had lots of experience of emergency care, it was her experiences of being an ED nurse and caring for older patients that were important to me and the study I was conducting. I think this was important because not once did she say 'you know what I mean Bobby'. Whenever I asked her to clarify a point she did so willingly. I felt accepted as a researcher and that was good. I think the strategy of starting the interview works. Research Journal (2013).*

It is evident that having a pre-understanding of the study site and participants posed a number of challenges for me as a researcher. A number of these have been discussed above. Nonetheless, a significant number of other challenges

were further associated with participant recruitment, interviewing and are explored in detail in the next section.

### **Recruitment**

A number of potential ethical issues were associated with adopting an insider approach (Thomas et al 2000). Ethical approval was gained from relevant ethical committees and is discussed in the methodology chapter. Specific concerns related not only to recruiting and interviewing participants who were my peers and colleagues, but also to maintaining their anonymity and confidentiality. The ethical approval process ensures that participating nurses cannot be identified when the findings are reported in any future publications resulting from the research (Toffoli & Rudge 2006).

According to McConnell-Henry et al (2009/10) ensuring that coercion or undue pressure does not occur during recruitment of peers and colleagues. Peers may feel pressured and believe they have no choice but to take part in the study due to the pre-existing relationship (McConnell-Henry et al 2009/10). Equally, they may also fear adverse consequences for their relationship with the researcher or their role or position at work if they do not participate (McDermid et al (2014). In considering these potential dilemmas, the voluntary nature of participation was certainly emphasised when advertising the study and reiterated during discussions about the research study with potential participants (McDermid et al 2014). Information relating to the study included the risks and benefits of taking part and the right to withdraw from the study at any time without repercussions. This was explained verbally and made explicit in the written information provided to the potential participants. Any potential participants who spoke to me even informally for further information regarding the study were told that accepting or refusing to take part in the study was voluntary and that they can take time to consider the information provided before making a decision.

As a nurse, I do not hold a managerial position within the ED. My role solely involves with practice development and education. Therefore, I was certain that

any nurse who volunteers to participate in the study would do so because they were interested in the study topic. Smith (1992) cited in McDermid et al (2014) suggests that participants may agree to be involved in a research to obtain future reciprocation. They may feel that agreeing to take part will be advantageous to their careers, such as providing better employment opportunities (McDermid et al 2014). From my interaction with participants these did not reflect the nurses' motivation to engage with the study.

Recruiting potential participants for the study involved putting up a small notice in the staff coffee room, inviting nurses to participate in the study. However, initially this did not yield any interest as no nurses asked me about the study. I thought this was because I was only in ED for two days a week and due to the department being very busy the nurses were too busy to ask further information or were not interested. Nonetheless, I realised one day that the invitation to the study was in the coffee room, an area that I seldom went to and this was where I needed to be to generate interest in the study. Once I started going to the coffee room for my official breaks with other nurses, interest in the study increased.

Sitting with my colleagues and peers in that coffee room initiated conversations and interest in the study as they were able to ask me what the study was about, why I was doing it and what did participation involve. Recruitment was facilitated by these informal conversations with potential participants. Smythe and Murray (2010) also identified that informal conversations with potential participants can, not only assist in determining suitability of interested individuals but also in discovering what expectations they may have in relation to involvement with the study. Reflecting back on these informal talks, I can honestly say that it helped to recruit the most experienced participants who could provide rich narratives of their experiences.

As an emergency care nurse I was well aware that at times nurses are very frustrated with the conditions and the lack of resources they have to work with. Therefore, I did not want potential participants to think that taking part in the



research was an opportunity for them to vent their frustrations. McConnell-Henry et al (2009/10) are of the opinion that participants may volunteer as they perceive the research process to be a forum for venting their frustrations. This was found by Thomas et al (2000) during their study:

*“There were a few instances in which nurses seemed to be using data collection as a way of communicating a specific problem (e.g., a problematic interaction with a supervisor) with the hope that some action would be taken. It was explicit in one case in which the participant commented, ‘I hope you can do something about this’”.*

Indeed being aware of this potential dilemma, I emphasised during the informal meetings that the study was not a forum in which to talk about their frustrations and/ or personal issues relating to other members of the ED team. Nonetheless, there was one more important issue which had the potential to impact on the recruitment process. This related to disparities of power and is discussed later in this chapter.

## **Interviewing**

Interviews were conducted and recorded with participants' consent, ensuring them that all attempts will be made to maintain their confidentiality and anonymity following the interviews. All efforts were made to protect the participants' identities and to ensure anonymity, and confidentiality (McDermid et al 2014). Interviews were recorded by numbers, participants were assigned a code number and their names were not used when probing or clarifying points during the interviews. This was also reflected in the interview transcription verbatim as illustrated below:

*B: from your experience can you describe an experience or incident when you were able to promote the dignity of an older patient in ED?*  
*Reply: yes.....it was a female patient.....*

Extract from interview 2 (2013).

In order to further protect the identity of participants, interviews were organised in advance and took place away from the ED. Each interview was private, with

time allocated for informal conversation prior to the start of the interview so that participants felt relaxed. Allowing time for participants to feel relaxed is associated with positively influencing the nature, length and ease of conversation (McDermid et al 2014). Qualitative interviews are designed to produce rich narrative data and for this data to be uncovered requires a positive relationship between the interviewer and interviewee (McDermid et al 2014: McConnell-Henry et al 2009/10). Conducting interviews with my colleagues and peers as already mentioned earlier certainly enhanced the stages of rapport building and thus a development of a positive relationship. When the researcher and participant have a pre-existing relationship McConnell-Henry et al (2009/10) suggest that the stages of rapport building are rapidly accelerated. Despite the benefits of interviewing your colleagues and peers I was very concerned with the risk of self-disclosure from my own perspective during the interviews. Even though I was very confident in interviewing my colleagues and peers, I also felt quite vulnerable in the sense that I may disclose to the participants my personal experiences or emotions, such as relating to my recent bereavement. My colleagues and peers knew that my mother had died and my grief had been unbearable. It is common for researchers to offer information about themselves in order to put participants at ease (McConnell-Henry et al (2009/2010)). However, the level of self-disclosure employed should not include personal experiences, beliefs and values (Hewitt-Taylor 2002) that could mitigate the participants' accounts and the study findings. To minimise this from happening I identified and recorded my thoughts prior to the data collection. This enabled me to evaluate the possible effects self-disclosure could have on the participants and data gathered. Prior to data collection I noted my concerns regarding disclosing my personal experiences:

*I have been preparing for data collection for a number of weeks. I have attended a 2 day qualitative interview course. I have read extensively in how to conduct interviews, especially with people you know. Combining the dual role of a researcher/interviewer and colleague will be difficult. However I feel I am prepared for this. I will have a general chat with the*

*participants before the formal interview and recording to put them at ease and make sure they are comfortable and relaxed.*

*I need to be clear as to what kind of information/chat I want to have with the nurses to make them comfortable. I want them to tell me their stories of caring for older people in ED. What are their experiences? How will they describe them? Should I talk to them about my own personal experiences? But these experiences are not from ED so why discuss them prior to interview? Also these are my personal experiences, they are in my consciousness. It is not my experiences being explored. I want to hear what they make of their own experiences. I will be initiating the interview. I am not the one being interviewed.*

*I am worried in case anyone of the nurses says anything about mattaji. I really don't want to end up crying although it is two years now. Most of the nurses probably don't even remember this. So why am I so worried? So what am I going to do?*

*Keep the conversation light prior to the recording - ask how they are?*

*Explain the aims of the study?*

*Verify consent again*

*Should I become distressed if anyone mentions mattaji- stop interview and not use the data collected as my being distressed could impact the nurses and contaminate the data. They may feel guarded in telling their experiences so as not to cause me sadness or distress. I need them to describe their experiences in depth without any influences.*

*(Research Journal March 2013)*

Similarly, it is also important when interviewing people you know to be aware of their emotional or unexpected responses or the possibility of over disclosure during data collection (McConnell-Henry et al 2009/2010). Being part of the ED and knowing all the participants I was not aware of any personal issues such as any previous personal experiences, recent bereavements or illness that could impact during the data collection. No issues were voiced by the participants during informal chats or during the rapport building chats prior to interviewing.

However, on reflecting back, I should have considered this and included potential strategies to minimise this. I did not at the time think that participants would have personal experiences similar to mine that could have impacted their responses or them emotionally. This was only through recent reflection that I developed an awareness of the emotional harm that might have been caused to the participants (Skene 2007) had they been vulnerable as I was at the time. Rowling (1999) suggests that prior to engaging in the interview, the researcher should have a clear strategy planned with regard to handling poignant responses. The only plan I had in place was that should the participants find describing their caring experiences stressful they would be offered a debriefing opportunity with a colleague lecturer from the university. However, time was spent with the participants after the interview to informally chat and discuss any issues or concerns. This was of paramount importance to a successful disengagement from the interviews and in reassuring the participants of their valuable contribution in terms of data collection (McConnell-Henry 2009/2010). Consequently, all the interviews went really well with no issues arising from the participants' perspective. Even though I had attended a two day course on qualitative interviewing I did not feel entirely confident in my ability to conduct qualitative interviews. Despite being a novice researcher I did manage to obtain rich data on ED nurses' experiences of caring for older people to illuminate their perceptions and understanding of dignity. The aim of the qualitative interviewing was to provide nurse participants with a platform to recount their experiences. The data collected was privileged; it was more than just words that were analysed. They were the voices of nurse who provide care to older people in ED every day.

### **Disparities of Power**

Being a member of the ED team and conducting research with my colleagues and peers was further associated with disparities in power. Hewitt-Taylor (2002) believes that the researcher and the participant hold equal power in the research process. The researcher has the power as seeker of knowledge, while

the participants are powerful as holders of that knowledge (McDermid 2014). Nevertheless, this has the potential to change the relationship between the researcher and the participants, potentially giving the participants greater power, as they hold the knowledge that is sought (McDermid 2014). The participants recruited for the study were various level registered nurses. Several were staff nurses, junior sisters, senior sisters and one was a clinical nurse manager of ED.

Conversely, as a senior nurse and holding an academic position within a university, I was worried that some of the junior nurses participating in the study might perceive me as more knowledgeable and powerful (Holian and Coghlan 2012). Being in this dual role, I had at some time or another been involved with the participants not only as a colleague but also as a teacher, mentor and advisor on educational studies. From my perspective they were valuable informants, in the research (Holloway & Wheeler 2010: 64) and holders of knowledge that I sought. Therefore, I did not want the junior nurses to see me as more powerful or knowledgeable than them. This I felt, could have restricted them from being open and honest in interviews and thus disclosing only what they think would be acceptable to me. I was also aware that they could, in the worst case scenario, have felt intimidated and threatened by me during the interviews. Similarly, I was also anxious that the participants may have volunteered to participate in the study out of loyalty or for personal gain such as support in academic studies (McConnell-Henry et al 2009/10).

The nature of the disparities in power was an important issue that required identification and the likely effects it could have on the research study. In undertaking research with colleagues, especially when participants are junior nurses, motivations have a more potential for negative consequences (McDermid et al 2014) such as those already discussed. I did not want these participants to feel that they were taking part for any reason other than that they were interested in the phenomenon of dignity and the knowledge and understanding the study was going to provide.

Acknowledging these shortcomings were important and practical steps to minimise included what Asselin (2003) believes is the importance of reinforcing the role of the researcher and the primary role of the participants within the research process. During recruitment as previously discussed, and prior to interviews I was very open about the nature of the study and the role of the participants, especially in terms of what was required from them. During informal chats I further emphasised that the information they would be divulging during the research interview will be their experiences of caring for older people and what these experiences means to them. Streubert and Carpenter (2011: 35) further confirm that researcher must be cognizant of the fact that the outcome of the interview is an understanding of the meaning of that experience for those who are part of it. Similarly, the participants must also understand this and the importance of committing to the research.

I identified and recorded a number of issues in my research journal, during the recruitment phase. They were valuable in recruiting the most suitable participants without the influence of any disparities in power. An example below illustrates this:

*Aim of the study is to explore ED nurses experiences of caring for older people. Nurses to be recruited must want to take part because they are interested in the study. So what am I looking for?*

*Experienced in ED*

*Have cared for older people in ED*

*Are willing to share those experiences*

*Are interested in taking part*

*Want to take part*

*Not volunteering because of my role in education and development?*

*In the coffee room today L asked me about the study. She said she would like to take part although she felt that she was very junior nurse having only been in ED for 18 months. Would she be suitable?*

*I explained the research process, how data will be collected, analysed and how the findings will be disseminated. I also told her to have a think*

*about it. She must only agree to take part if she wanted to. As for suitability she has the desired level of experience.*

*Then I am also now thinking is she really is interested or is she only doing it because out of loyalty to me? I do remember that about 6 months I did taught her a number clinical skills such as plastering, wound closure.....*

*My role includes informing, guiding, encouraging and organising nurses to participate in academic studies.....? These must not be her influencing factors!*

Research Journal (2013)

Much of the literature concerned with insider research suggests that conducting research with peers and colleagues puts the insider researcher in a relatively powerful position and issues relate to offsetting this imbalance. In contrast, Green and Thorogood (2014: 110) suggest that many health research studies involve interviews with those who are relatively more powerful than the interviewer. Interviewing health service managers presents somewhat different problems of 'cultural difference' if the interviewer is a student, or a less powerful health professional (Green & Thorogood 2014: 110). These authors suggest that if managers are invited to participate in a study in their professional role, they may be speaking 'for their organisation' rather than talking about personal experiences. This was an issue I faced because one of the participants, taking part in the study was a nurse manager of ED. Although, the nurse manager was in a similar pay band to me and was also a nurse with over twenty years of emergency nursing experience, her job title was manager. As a manager she was responsible for managing all the ED nurses and that included me. My nursing role involved working in collaboration with her to assess, plan and deliver education and training to all the emergency care nurses. Furthermore, this collaborative role also included interviewing candidates during recruitment of nurses for the ED. Therefore, in interviewing this manager was a challenge as disparities in power were reversed in this situation. The manager was certainly more powerful than me as I was the student conducting this research.

Moreover, I was concerned that, even though she had volunteered to participate in the research in her role as an emergency care nurse, she could 'talk for the organisation', rather than about her own experiences of caring for older patients in the ED. Prior to the interview with her, I deliberated over this as to how I was going to react or feel if the interview did not elicit the desired outcome. In organising all interviews in advance gave me the opportunity to mentally prepare for the interviews by writing my thoughts and feelings in the research journal. For example, prior to this interview I wrote:

*So far all my interviews have gone really well. I am going to be interviewing H tomorrow and in reality she is my manager, but also an equal colleague. But then she has managerial responsibilities too. I do feel very nervous about interviewing my manager even though I have interviewed a number of people with her but never interviewed her. I feel as if I am going to be interviewing my 'boss'. It does not feel right! It feels odd really!*

*She has so much emergency care experience and it is those experiences that I want her to tell. I want her to describe her experiences of caring older people. I don't want her to be talking about ED as an organisation or policies.....*

*I am hoping that we will feel equal -this is not related to work but to the research I am conducting?*

*Will we still have the same relationship after the interview?*

*I am not going to change anything in the way I have conducted the previous interviews. I will start the interview as I start all the other interviews with general chat etc.....*

(Research Journal August 2013)

When the interview did take place, no issues that were of concern to me became apparent. All my fears of being nervous disappeared. I was the interviewer asking the questions. As soon as I had asked the first question, it was obvious that the nurse manager was only interested in describing her first-hand experiences of nursing in ED. It was as if enabling her to tell her stories



empowered her. Empowerment is not the only potential and significant benefit for the participant: appreciation that someone has authentically listened to the participants can also be a benefit and can emphasise the cathartic dimension of the experience (Morse and Field 1995). Indeed, it was evident that the nurse manager was participating because she wanted to engage in the research process and she understood what was required from her as a participant. This was her opportunity to tell her stories of caring for older people. My concerns and doubts were unfounded in this case, but it was important to be open about how I felt in conducting this interview. Immediately after the interview with the manager, I wrote in my research journal:

*Well, the interview went very well. I don't know why I was so worried. The format of the interview was the same as all interviews. During the interview it did not feel as if I was interviewing my manager. It felt normal as if I was interviewing any other participant. I was able to probe and clarify points when and as required. H described her experiences of being 'clinical' and caring for patients. She did not talk about her experiences of being a manager. All her stories related to patient care which was what the aim of the interview was.*

*I think our relationship will continue as before and we will still be working collaboratively within our roles.*

(Research Journal August 2013)

My thoughts and feeling regarding all the interviews were represented in the research journal. I wrote my personal fears and thoughts of potential difficulties that could have impacted on the interviews. As Ortlipp (2008) commented the interviewer's thoughts, feelings, fears, and desires can impact on the interviews, but they are not necessarily visible in the data or the transcripts. The process of reflection helps to bring the unconscious into consciousness and thus open to inspection.

### **Issues in Dissemination**

A significant issue associated with 'insider' research relates to maintaining confidentiality in disseminating the results of insider research results. The issue of confidentiality becomes more prominent and challenging when research is conducted with colleagues and peers in the workplace. McDermid et al (2014) believe that this relates to others in the workplace being able to deduce participants' identities from the information provided. Furthermore, it is also important that the confidentiality of the organisation is maintained, especially, if the findings do not reflect a positive picture of the setting where the study was conducted (Thomas et al 2000).

Even though I kept a record of the demographic details (status of participant such as staff nurse etc., years of ED experience) of the participants, these will be destroyed with the interview tapes following completion of the thesis. A primarily report of the findings has already been shared with participants so that they were reassured that every effort has been made to maintain their privacy and confidentiality. Further dissemination is planned.

### **Summary**

The purpose of this chapter was to explore the issues and challenges associated with conducting research with my peers and colleagues in my workplace. It is clear that a number of advantages were associated with the insider research such as gaining access and participant recruitment. In contrast a number of challenges were also evident and these have also been addressed. It is clear that there were costs and benefits to conducting an insider research. Nevertheless, these were carefully considered and documented. Keeping a reflective journal of my personal biases and perspectives reduced the potential challenges associated with insider research (Dwyer and Buckle 2009).

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